MEDICAL HISTORY UPDATE

Child's Full Name: _____ Date of birth: _____ _____ _____

Home Address: _____

Telephone Number: _____

Email Address: _____

Name of Dental Insurance: _____

Subscriber's Social Security Number/ Member ID: _____

CHECK ONE:

☐ There have NOT been any significant changes in my child's health since their last dental visit.

☐ There HAVE BEEN changes in my child's health, new diagnoses, and/or new medications since their last regular dental check-up. Please list any changes in health or new medications below.

Parent or Legal Guardian's Name Printed

Parent or Legal Guardian's Signature Date

PAYMENT AND NO SHOW POLICY

Payment Policy:

The parent or guardian who brings the child to their visit is responsible for payment.

Payment is due at time of service. This includes any co-pays or deductibles or any fee that may not be covered by insurance.

We accept: Visa, Master Card, American Express, Discover, debit cards, and cash.

- There will be a $25 charge for any returned checks

We also accept Care Credit as a way to help finance your child's dental needs.

We are in network with many insurance providers. We will always do our best to give you the most accurate estimate before each appointment so that there are no surprises. In order to facilitate this, we request that **ALL** information is submitted to the insurance company and provided to SIPD prior to your appointment. In such cases when accurate documentation is not provided, you will be responsible for all charges.

If you happen to be out of network, most likely there are still benefits to you. For your convenience, our business staff will file the insurance claim for you.

Cancellation/No-Show Policy:

$25 charge for less than 24 hours' notice for all appointments
$100 charge per no show treatment appointments

We kindly request 2 working-days' notice to cancel or change appointment times. We understand that unforeseen circumstances can arise.

Late afternoon appointments are highly requested, if you miss (or late cancel) one of these appointment times you may not be allowed to schedule late afternoon appointments in the future.

We would be happy to answer any questions that you may have regarding our payment/No-Show policy. Any questions should be directed to our Operations Manager Ashley Moorman.

I have read and understand the Payment Policy of Southern Illinois Pediatric Dentistry and any questions that I have had have been answered to my satisfaction.

Print Name

Parent or Legal Guardian's Signature Date

HIPAA Release of Information

1.) **Patient Name**:_____

First Name / Middle Name / Last Name

2.) **Patient Date of Birth**: _____

3.) **Below I have listed person/s I approve Southern Illinois Pediatric Dentistry to release by child/s dental information to:**

A.)_____ Phone Number: _____

B.) _____ Phone Number: _____

C.) _____ Phone Number: _____

D.) _____ Phone Number: _____

The information that is allowed to be disclosed to this person/s: (Please check-mark each that applies)

_____ Account information (Financial status/outstanding balance)

_____ Outstanding or Current treatment

_____ Upcoming appointment dates/times

Authorization and Signature: I authorize the release of my child/s confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of Parent/Legal Guardian: _____

Printed name Parent/Legal Guardian: _____

• SOUTHERN ILLINOIS •
Pediatric Dentistry

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as “Coronavirus”, at any time or in any place. Be assured that we have always followed the CDC and ADA guidelines in regards to the use of personal protective equipment and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to sterilization, disinfection, and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might at your gym, grocery store or favorite restaurant. “Social Distancing” nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patients, dentist, dental staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes ☐ No ☐

X _____ Date:_____

Parent/Guardian signature

DESIGNATION OF AUTHORIZED ADULT REPRESENTATIVE(S) AND HIPAA RELEASE

In my absence, I do hereby give permission to the following individual(s) to bring my child or children to Southern Illinois Pediatric Dentistry to seek dental care and release dental information. This includes account information, outstanding or current treatment and or upcoming appointment dates/times.

Any of the areas being released that should *not* be, please notify the office and describe restrictions below:

_____

Patient name: _____ D.O.B.: _____

Name	Relationship to child	Phone

I understand that care will be provided by the hygienists and the dentist, including administration of treatment or antibiotics as deemed necessary by the dentist at the time. I will make every effort to call Southern IL Pediatric Dentistry office with any questions I have about my child's care following any visit I am not present. I understand that until I provide written notice to the practice of any changes to the designation of authorized adult representatives, Southern IL Pediatric Dentistry may rely on the consent to provided herein.

I authorize the release of my child or children's confidential protected dental information. I understand that this authorization is voluntary and that the information to be disclosed is protected by law. The information that is used and or disclosed associated to this authorization may be redisclosed by the recipient unless the recipient is covered by state laws that limit the use or disclosure of my confidential protected dental information.

Print Name Relationship to patient

Parent or Legal Guardian's Signature Date