Southern Illinois Pediatric Dentistry of Edwardsville

SOUTHERN ILLINOIS Pediatric Dentistry OF EDWARDSVILLE

Required Dental Insurance Update

Patient's Name: ____ Date of birth: ____________________________

Home Address: ____

Phone Number: __________________________________ Email: ____

Primary Insurance

Insurance Company: ____

Name of Insured: ____ Date of Birth: ___________________________

ID/SSN: ____________________________________ Group Number: _______________________________

Insurance Telephone Number: ____

Employer Name: ____

Secondary Insurance

Insurance Company: ____

Name of Insured: ____ Date of Birth: ___________________________

ID/SSN: ____________________________________ Group Number: _______________________________

Insurance Telephone Number: ____

Employer Name: ____

*We do **NOT** accept Medicaid as secondary insurance*

IF YOU ARE SELF PAY – CHECK BELOW & SIGN

☐ I do not carry dental insurance and understand I am responsible for all charges.

____

Parent or Legal Guardian's Signature Date

Southern Illinois Pediatric Dentistry of Edwardsville
Required Medical History Update

Child's Full Name: ____ Date of birth: _________________________

Gender: M / F Height: ___________ Weight: __________ Date of last physical exam: ________ / ______ / __________

Name/Address/Phone # of Primary Physician: ____

Name/Address/Phone # of Medical Specialist: ____

Is your child being treated by a physician at this time? Reason: ____ YES / NO

Is your child taking any medication, Vitamins or supplements? (Prescription or over the counter) YES / NO

List name, dose & date started: ____

Has your child ever been hospitalized, had surgery or been treated in the ER? YES / NO

List date & Describe: ____

Has your child ever had a problem with an anesthetic? Describe _______________________________________ YES / NO

Has your child ever had a reaction or allergy to an antibiotic or medication? List: __________________________ YES / NO

Is your child allergic to latex or anything else such as metals, acrylic etc.? List: ____________________________ YES / NO

Is your child up to date on immunizations against childhood diseases? YES / NO

Please mark YES or NO for the following medical conditions:

Condition		Condition	
Abnormal bleeding/ Hemophilia	YES / NO	Heart Murmur	YES / NO
Anemia	YES / NO	Hepatitis / Liver Problems	YES / NO
Asthma	YES / NO	Hydrocephaly / Shunt Problems	YES / NO
Autism	YES / NO	Hypertension	YES / NO
Complications at birth	YES / NO	HIV / AIDS	YES / NO
Cancer	YES / NO	Kidney / Bladder Problems	YES / NO
Congenital Heart Defects	YES / NO	Neurological Disorder	YES / NO
Cystic Fibrosis	YES / NO	Pneumonia	YES / NO
Developmental Disorders	YES / NO	Seizures	YES / NO
Gastroesophageal / Acid Reflux	YES / NO	Sinus Problems	YES / NO

Please list any other medical considerations our office should be aware of: ____________________________________

Dental Issues:

Please check if your child is having any problems with the following:

☐ Cavities ☐ Toothache ☐ Sensitive Teeth ☐ Trauma ☐ Color of Teeth ☐ Orthodontics

☐ Jaw Sounds ☐ Gum Infection ☐ None

Please list any other concerns you have for your child's teeth:____

____

____

Parent or Legal Guardian Signature Date

Southern Illinois Pediatric Dentistry of Edwardsville

SOUTHERN ILLINOIS Pediatric Dentistry OF EDWARDSVILLE

Guardianship Form

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 with 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

TO DENY PERMISSION – CHECK BELOW & SIGN

☐ I do hereby **DENY** permission for anyone other than a parent or legal guardian to bring my child to Southern Illinois Pediatric Dentistry for dental treatment and/or to receive or release dental information.

Southern Illinois Pediatric Dentistry of Edwardsville

SOUTHERN ILLINOIS Pediatric Dentistry OF EDWARDSVILLE

Financial 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 and for no show checkup hygiene appointments

$100 charge for less than 24 hours' notice and for 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