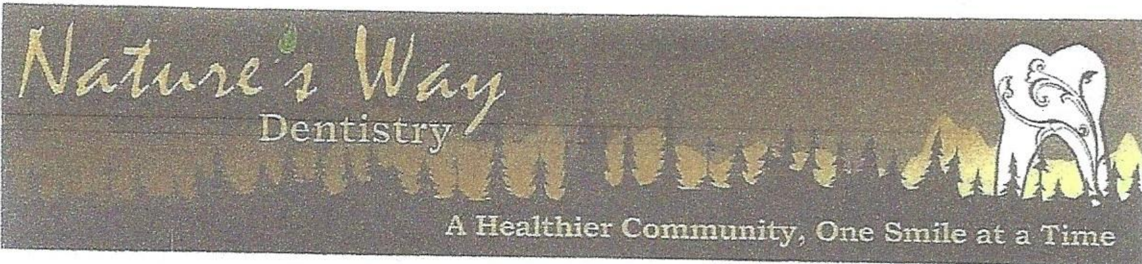

CONSENT FOR PEDIATRIC DENTAL TREATMENT

Child's Full Name: ____

Date of Birth: ____

If you are unable to be present in the dental office while your child is receiving dental treatment the following circumstances will apply:

> *I am leaving the treatment of my child to the doctor's judgment and experience. I understand that the treatment rendered to my child by Dr. Werner and any member of his team is within the scope of routine hygiene and restorative care and give Dr. Werner and his staff permission to treat my child as they feel necessary.*

Emergency Contact Name: ____

Relationship to Patient: ____

Phone Number: ____

This consent is for the duration that the below named minor patient is undergoing treatment at our office as a patient of record. This consent is terminated in the event that the minor becomes 18 years of age or when the parent or guardian revokes consent in writing to Dr. John A. Werner.

Parent or Legal Guardian (Print):____

Parent or Legal Guardian Signature:____

Date: ____

Nature's Way Dentistry

Patient Information

Name ______________________ Address ________________

City ______________________ State ________ Zip ________

Phone ____________ ____________ ____________

Preferred Home ☐ Cell ☐ Business ☐

Email ____

Confirm appointments via Text ☐ Email ☐ Call ☐

If text option selected, provider

AT&T ☐ Verizon ☐ Sprint ☐

T-Mobile ☐ Other ________________

If you select confirm via text, you are agreeing to pay for any related charges

Birthdate ________ SSN ________________ Gender F M

Marital Status Married ☐ Single ☐

Employer ________________________________

Employee Status FT ☐ PT ☐

Occupation ________________________________

Primary Dental Insurance (Name of Company) ________________

Policy Holder Self ☐ Spouse ☐ Parent ☐

Policy Holder Name (If different than self) ________________

Insurance ID ________________

Group Number ________________

Policy Holder's Birthdate ________________

Policy Holder's SS# ________________

Consent For Disclosing Personal Health Information:

Relation: Self ☐ Spouse ☐ Parent ☐

Name of Authorized Person: ________________

Phone Number: ________________

What Can We Disclose? ________________

Sign and Date: ________________

How did you hear about us? (If refered by a friend, include their name).

____

Nature's Way Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, ______________________________, have received a copy of this office's
(PLEASE PRINT YOUR NAME)

Notice of Privacy Practices.

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify:

____

____

____

Last Updated 01 October 2015

Appointment Policy

Instruments, chairs and personnel are reserved exclusively for your appointment. Last-minute cancellations and no-shows are expensive to our patients and our practice. **No-shows, cancellations day of, or appointments cancelled less than 2 business days in advance are considered failed appointments.**

- We understand that extenuating circumstances occur, so the 1st failed dental appointment incurs a warning.
- After a failed appointment, a 50% copay deposit is required to reserve an appointment.
- After a 2nd failed appointment, a 100% copay deposit is required to reserve an appointment.
- After a 3rd failed appointment, will result in dismissal for our office

This charge is not a penalty. It is a portion of your copay charged at the time your appointment is scheduled. Your copay deposit will directly apply to your treatment at the time of your visit. Your copay deposit is not refundable. Should you fail your appointment, your copay will be forfeited in addition to a $50 cancellation fee.

A 3rd failed appointment will result in dismissal from Nature's Way Dentistry. *Our office is appointment-based, and cannot provide this level of flexibility in our schedule.* We will assist you in finding another dentist to accommodate your scheduling needs.

Our appointment policy exists to keep costs down. Nature's Way Dentistry is proud to offer the highest level of care, the highest quality materials and the best patient experience in the area. We are also proud to offer these services at a reasonable cost. Above all, failed appointments are expensive to our patients and our practice and we cannot accommodate failed appointments into our business model.

I, ______________________________________, agree to these terms.

Signature ____ Date___________

Financial Agreement

PATIENT PORTION IS DUE AND PAYABLE AT TIME OF SERVICE; YOU WILL BE REQUIRED TO PAY TODAY.

If you cannot pay for your appointment today, payment arrangements must be made before your scheduled appointment. **Payment options:** 1. Check 2. Credit Card 3. Payment Plans with Care Credit

PATIENTS WITH INSURANCE: As a courtesy we will do one eligibility check to see if you are covered. You have seven (7) days to provide us with the correct dental insurance information; otherwise we will bill you directly for the full balance of your appointment and the balance is your responsibility.

The PATIENT is responsible for the non-covered portion of procedures and/or deductibles at the time of the service. The quote for treatment cost provided to you is an **estimate. Treatment costs may be higher or lower than the estimate.** If the insurance company does not pay after 60 days, we will bill you directly for the full balance. After insurance has paid their portion, and there is any cost remaining, you will get a statement with the remaining balance and it is your responsibility to pay in the time stated on the statement.

If you have questions about what your insurance coverage we are happy to provide a pre-authorization for coverage, at your request. This is just an estimated quote of cost for treatment and is not a guarantee. *Any other questions regarding coverage should be addressed to your insurance company.*

- **Parents not accompanying their child** to an appointment must make PRIOR arrangements for payment
- **Parents accompanying their children** are financially responsible for payment.
- There is a $30.00 processing charge for **non-sufficient funds** or returned checks.

Because instruments, chairs, and personnel are reserved exclusively for your appointment, there is a **$50 CHARGE FOR CHANGED OR BROKEN HYGIENE AND RESTORATIVE APPOINTMENTS LESS THAN 2 BUSINESS DAYS IN ADVANCE OR LESS THAN 24 HOURS IN ADVANCE**.

PATIENTS WILL BE CHARGED THE FULL AMOUNT FOR CROWN, ROOT CANAL AND 2 HOUR OR GREATER APPOINTMENTS CANCELLED LESS THAN 2 BUSINESS DAYS IN ADVANCE.

REFUND POLICY

No refunds will be granted for services or procedures already performed at this office. Patients may cancel treatment with no charge if the appointment is cancelled 2 or more business days before the natural teeth are prepared or altered. **After tooth preparation has occurred, patients are liable for the full cost of services if they choose to not complete treatment.**

I authorize my insurance benefits be paid directly to the physician, I understand that I am financially responsible for any balance. I also authorize Nature's Way Dentistry or my insurance company to release any information required to processes my claims.

Signature ______________________________ Date______________

Name (Printed) ______________________________

Medical Health History:

All information is strictly confidential but required for optimal treatment

Do you have, or have you had, any of the following?

Yes

- Heart Problems
  - Chest Pain ☐
  - Shortness of breath ☐
  - Blood pressure problem ☐
  - Heart murmur ☐
  - Heart valve problem ☐
  - Taking heart medication ☐
  - Rheumatic fever ☐
  - Pacemaker ☐
  - Artificial heart valve ☐
- Blood Problems
  - Easy bruising ☐
  - Frequent nosebleeds ☐
  - Abnormal bleeding ☐
  - Blood disease (anemia) ☐
- Allergy Problem
  - Hay Fever ☐
  - Sinus problems ☐
  - Skin rash ☐
  - Taking allergy medication ☐
  - Asthma ☐
- Intestinal Problems
  - Ulcers ☐
  - Weight gain or loss ☐
    - How much? ______
    - Over how long? ______
  - Special diet ☐
  - Constipation/Diarrhea ☐
  - Kidney or bladder problems ☐
- Bone or Joint Problems
  - Arthritis ☐
    - Rheumatoid ☐
  - Back or neck pain ☐
  - Joint replacement ☐
    - Which joint? ______
- Fainting Spells, Seizures, or Epilepsy ☐
- Stroke(s) ☐
- Frequent or severe headaches ☐
- Thyroid problems ☐
  - Hypothyroid ☐
  - Hyperthyroid ☐

Mild Moderate Severe

- Persistent cough or swollen glands ☐
- Premedications required by physician ☐
- Cancer/Tumor ☐

Type of cancer and location: ______

______

Date Diagnosed: ______

Yes

- Diabetes: Please note Type I or Type II: ☐
  - Current Average Blood Sugar Reading: ______
  - Thirsty or mouth is dry much of the time ☐
  - Family history of diabetes ☐
- Tuberculosis or other respiratory disease ☐
- Do you drink alcohol? ☐
  - If so, how much? ______
- Do you smoke? ☐
  - If so, how much? ______
- Hepatitis, jaundice, or liver trouble? ☐
- Sexually Transmitted Disease ☐
- If yes, what ______
- HIV-positive/AIDS ☐
- Glaucoma ☐
- History of head injury? ☐
- Epilepsy or other neurological disease? ☐
- History of alcohol or drug abuse? ☐
- Do you have a disease, condition, or problem not listed previously that you feel we should know about?
  - If so, please describe: ______

During the last 12 months have you taken the following?

- Antibiotics or sulfa drugs ☐
- Anticoagulants (e.g. Coumadin) ☐
- High blood pressure medicine ☐
- Tranquilizers ☐
- Insulin, Orinase, or similar drug ☐
- Aspirin ☐
- Digitalis or drug for heart trouble ☐
- Nitroglycerin ☐
- Cortisone (steroids) ☐
- Natural remedies ☐
- Nonprescription drug/supplements ☐

Women

- Are you taking contraceptives or other hormones? ☐
- Are you pregnant? ☐
  - If so, expected delivery date: ______
- Are you nursing? ☐
- Have you reached menopause? ☐

Have you taken and/or adversely reacted to any of the following?

- Local anesthetics ("Novacaine") ☐
- Penicillin or other antibiotics ☐
- Sulfa drugs ☐
- Barbiturates, sedatives, or sleeping pills ☐
- Aspirin, Acetaminophen, or Ibuprofen ☐
- Codeine, Demerol, or other narcotics ☐
- Reaction to metals ☐
- Latex or rubber dam ☐
- Fosamax or other osteoporosis medications
  - If yes, what ______

Other: ______

Current Medications

Please list any current or previous medications. More space is provided on the back of this sheet if necessary.

Medication	Dosage	Frequency

Dental Health History

All information is strictly confidential but required for optimal treatment

Do you have, or have you had, any of the following?

		Yes
Does food catch between your teeth		☐
Do you have difficulty chewing your food		☐
Do you avoid brushing any part of your mouth because of pain?		☐
Do your gums bleed easily?		☐
Do your gums bleed when you floss?		☐
Do your gums feel swollen or tender?		☐
Have you ever noticed slow healing sores in or around your mouth?		☐
Are you teeth sensitive to:		
Hot foods or liquid?		☐
Cold foods or liquid?		☐
To sweets?		☐
Do you take fluoride supplements?		☐
Are you dissatisfied with the appearance of your teeth?		☐
How often do you brush?		
How often do you floss?		
Are you aware of an uncomfortable bite?		☐
Have you had a blow to the jaw (trauma)?		☐

		Yes
Do you clinch or grind your jaw:		☐
During the day?		☐
During the night?		☐
Does your jaw ever lock?		☐
Does it hurt when you chew or open wide to take a bite?		☐
Do your jaw joints ever ache?		☐
Do you have any jaw symptoms or headaches upon awaking in the morning?		☐
Do you find jaw pain or discomfort extremely frustrating or depressing?		☐
Do you take medications or pills for pain or discomfort? (Pain relievers, muscle relaxants, antidepressants)		☐
Do you have a temporomandibular (jaw) disorder (TMD)?		☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?		☐
Why and what area?		

Treatment Policy

Please read each statement for understanding of our office treatment policies

Upon such diagnosis, I authorize the doctor or designated staff to perform all recommended treatment mutually agreed upon by us and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medications as necessary.

I fully understand that doing dental procedures, standard cleanings, and using anesthetic agents and doing injections embodies certain risks, and though rare, I accept the danger of such risks.

I understand that I can ask for a complete recital of any possible risk at anytime.

I certify that I have read, understood, and agree to the above treatment policy and information in this packet. I have been given the opportunity to ask any questions and the staff at Nature's Way Dentistry has answered them to my understanding. The information in this packet is filled out to the best of my knowledge and I understand that providing incorrect information can be dangerous to my health.

Name (Printed) ______________________ Date: ______________

Signature: ______________________________