



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

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:

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 referred by a friend, include their name).

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 and are subject to immediate dismissal including new prospective patients.**

- 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.

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.

- After a **2nd failed** appointment, paying 100% in full before scheduled appointments is required to reserve for the next appointment.
- After a **3rd failed** appointment, will result in dismissal from our office.

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, 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 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 plan with Care Credit.

I understand that I am responsible for all charges for the care I receive. If I do not have dental insurance coverage, I will pay all amounts for which I am responsible in full, at time of service of treatment. It is my responsibility to provide accurate and up to date information regarding my dental insurance coverage. Failing to do so may result in being responsible for 100% of payment.

PATIENTS WITH INSURANCE: As a courtesy we will do an eligibility check to see if you are covered. You have (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 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.

PATIENTS WITH OUT OF NETWORK INSURANCE: If my treating dentist is not a participating provider with my insurance, I will be required to pay for all treatment in full, at time of service. The practice may file for insurance coverage as a courtesy. If any coverage is paid, payment will be reimbursed directly to you from your insurance company.

If you have questions about 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 through your insurance company.

- **Parents not accompanying their children** 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 **\$50.00 charge for changed or broken hygiene and restorative appointments less than 2 business days in advanced.**

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

REFUND POLICY

No refunds will be granted for services or procedures already preformed 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 process 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		Yes
Heart Problems		Diabetes: Please note Type I or Type II:	
Chest Pain		Current Average Blood Sugar Reading:	
Shortness of breath		Thirsty or mouth is dry much of the time	
Blood pressure problem		Family history of diabetes	
Heart murmur		Tuberculosis or other respiratory disease	
Heart valve problem		Do you drink alcohol?	
Taking heart medication		If so, how much?	
Rheumatic fever		Do you smoke?	
Pacemaker		If so, how much?	
Artificial heart valve		Hepatitis, jaundice, or liver trouble?	
Blood Problems		Sexually Transmitted Disease	
Easy bruising		If yes, what	
Frequent nosebleeds		HIV-positive/AIDS	
Abnormal bleeding		Glaucoma	
Blood disease (anemia)		History of head injury?	
Allergy Problem		Epilepsy or other neurological disease?	
Hay Fever		History of alcohol or drug abuse?	
Sinus problems		Do you have a disease, condition, or problem not listed	
Skin rash		previously that you feel we should know about?	
Taking allergy medication		If so, please describe:	
Asthma			
Intestinal Problems		During the last 12 months have you taken the following?	
Ulcers		Antibiotics or sulfa drugs	
Weight gain or loss		Anticoagulants (e.g. Coumadin)	
How much?		High blood pressure medicine	
Over how long?		Tranquilizers	
Special diet		Insulin, Orinase, or similar drug	
Constipation/Diarrhea		Aspirin	
Kidney or bladder problems		Digitalis or drug for heart trouble	
Bone or Joint Problems		Nitroglycerin	
Arthritis		Cortisone (steroids)	
Rheumatoid		Natural remedies	
Back or neck pain		Nonprescription drug/supplements	
Joint replacement			
Which joint?		Women	
Fainting Spells, Seizures, or Epilepsy		Are you taking contraceptives or	
Stroke(s)		other hormones?	
Frequent or severe headaches		Are you pregnant?	
Thyroid problems		If so, expected delivery date:	
Hypothyroid		Are you nursing?	
Hyperthyroid		Have you reached menopause?	
Mild Moderate Severe		Have you adversely reacted to any of the following:	
Persistent cough or swollen glands		If yes, please list the type of reaction on line.	
Premedications required by physician		Local anesthetics ("Novocain")	
Cancer/Tumor		Penicillin or other antibiotics	
Type of cancer and location:		Sulfa drugs	
		Barbiturates, sedatives, or sleeping pills	
		Aspirin, Acetaminophen, or Ibuprofen	
		Codeine, Demerol, or other narcotics	
		Reaction to metals	
		Latex or rubber dam	
		Have you ever taken Fosamax or other osteoporosis drugs?	
		If yes, what	
		Other:	

Signature: _____ DATE: _____

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		Yes
Does food catch between your teeth	☐	Do you clinch or grind your jaw:	☐
Do you have difficulty chewing your food	☐	During the day?	☐
Do you avoid brushing any part of your mouth because of pain?	☐	During the night?	☐
Do your gums bleed easily?	☐	Does your jaw ever lock?	☐
Do your gums bleed when you floss?	☐	Does it hurt when you chew or open wide to take a bite?	☐
Do your gums feel swollen or tender?	☐	Do your jaw joints ever ache?	☐
Have you ever noticed slow healing sores in or around your mouth?	☐	Do you have any jaw symptoms or headaches upon awaking in the morning?	☐
Are you teeth sensitive to:		Do you find jaw pain or discomfort extremely frustrating or depressing?	☐
Hot foods or liquid?	☐	Do you take medications or pills for pain or discomfort? (Pain relievers, muscle relaxants, antidepressants)	☐
Cold foods or liquid?	☐	Do you have a temporomandibular (jaw) disorder (TMD)?	☐
To sweets?	☐	Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐
Do you take fluoride supplements?	☐	Why and what area?	
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)?	☐		

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: _____