Welcome

Tell Us About Your Child

Today's Date: _____ Child's Home Phone #: (____)_____ Social Security #: _____

Child's Name: _____ Child's Birthdate: ____/____/____ Child's Age: _____
Last First MI

Nickname: _____ ❑ Male ❑ Female School: _____ Grade: _____

Child's Home Address: _____
Street City State Zip

Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No Is the child adopted? ❑ Yes ❑ No Is the child in a foster home? ❑ Yes ❑ No

Whom may we Thank for referring you? _____ Other siblings seen by us: _____

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street City State Zip

Parent's Information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single

Mother: ❑ Step Mother ❑ Guardian Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____)_____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Father: ❑ Step Father ❑ Guardian Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____)_____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____
Street City State Zip

Employer: _____ Length of Employment: _____

Person Responsible for Account

Name: _____ Relationship: _____ Social Security #: _____

Billing Address: _____
Street City State Zip

Work Phone #: (____)_____ Home Phone #: (____)_____ Employer: _____ Driver's License #: _____

Who is responsible for making appointments?

Name: _____ Work Phone #: (____)_____ Home Phone #: (____)_____ Best time to call: _____

Insurance Information

Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ Social Security #: _____ Policy Owner's Employer: _____

Employer's Address: _____
Street City State Zip

Dental Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____
PO Box/Street City State Zip

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____ Social Security #: _____ Policy Owner's Employer: _____

Employer's Address: _____
Street City State Zip

CONTINUED ON BACK

Dental History

Is the child currently in pain? ❑ **Yes** ❑ **No** **What is the primary reason for today's visit?** _____

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑ **Yes** ❑ **No**

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No Is the child taking fluoridated supplements? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: _____ Date of Last Visit: _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least about? _____

Does / did the child have any of the following habits?

Y N	Breast Fed	Y N	Mouth Breather	Y N	Thumb / Finger Sucking
Y N	Chewing on Objects	Y N	Nail Biting	Y N	Tongue / Cheek Biting
Y N	Clenching / Grinding Teeth	Y N	Nursing Bottle Habits	Y N	Tongue Thrust
Y N	Lip Sucking / Biting	Y N	Speech Problems	Y N	Used Pacifier

Medical History

Child's Physician: _____ Phone #: (_____)_____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

Please list all drugs that the child is currently taking: _____

Please list all drugs and/or other things that cause the child allergic reactions: _____

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

Has the child had/experienced any of the following:

Y N	Abnormal Bleeding	Y N	Diabetes	Y N	Low Blood Pressure
Y N	AIDS / HIV+	Y N	Epilepsy	Y N	Lupus
Y N	Allergies	Y N	Handicaps / Disabilities	Y N	Measles
Y N	Anemia	Y N	Hearing Impairment	Y N	Mitral Valve Prolapse
Y N	Any Hospital Stays / Operations	Y N	Heart Murmur	Y N	Mononucleosis
Y N	Asthma	Y N	Hemophilia	Y N	Rheumatic Fever
Y N	Blood Transfusion	Y N	Hepatitis	Y N	Scarlet Fever
Y N	Cancer	Y N	High Blood Pressure	Y N	Sickle Cell Anemia
Y N	Chicken Pox	Y N	Hives	Y N	Skin Rash
Y N	Congenital Heart Defect	Y N	Kidney Problems	Y N	Tonsillitis
Y N	Convulsions	Y N	Liver Problems	Y N	Tuberculosis (TB)

Please discuss any serious medical problems the child experiences/ed: _____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. My method of payment will be _____.

_____
Signature of parent or guardian Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of parent or guardian Date

The parent or guardian who accompanies the child is responsible for payment at time of service.

MJY
Michael J. Young D.D.S.
Family and cosmetic Dentistry

626 Verot School Road Suite D
Lafayette, LA 70508
(337) 237-6453
www.23smiles.com

Insurance and Financial Policy

At Michael Young DDS, we believe that you deserve the best care. That is why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to many patients. Some have dental benefits, but some do not. If you have dental benefits, congratulations! You are very fortunate. Here are some important things that you should know:

- Your dental benefits are based upon a contract between your employer and an insurance company. **If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**
- We currently accept all private insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service), but are only **in network with Delta Dental Premier, Blue Cross Blue Shield of LA Key Dental, Cigna Pro and Principal Financial Group PPO.** This means we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but is **ONLY AN ESTIMATE.** If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not guarantee of coverage. This does delay treatment but will give the exact out of pocket figures that you may require.
- Your insurance company may try to confuse you by claiming fees or procedures are not "customary". This is their method of saying that they will not pay beyond arbitrary limits set in your policy. For instance, your insurance policy may state that it covers 80% of "reasonable and customary" fees. This does not mean you will receive 80% of your doctor's fees. This statement means you will receive 80% of an arbitrary amount set by your insurance company so they continue to make profit.
- We will bill your insurance as a courtesy. If insurance does not pay within 90 days, **Michael Young DDS** reserves the right to request payment in full for services from you and let you collect the insurance funds due to you. This is rare but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be, part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.
- **Michael Young DDS** reserves the right to place patients in collections for payment in full plus $14.00 collection charge after 60 days or two payment requests.
- **Michael Young DDS** does require payment in full for your portion at time of service. We accept MasterCard, Visa, American Express, Discover, and Cash. **We do not accept checks.** If you are in need of an extended finance option, we also work with CareCredit, which offers 6 or 12 month interest free "same as cash".
- A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change appointment, we require **at least 24 hour** notice to avoid a **$35 cancellation fee** (emergencies are an exception).
- In the event of an emergency after regular business hours, a **$100 emergency fee** will be charged for established patient in addition to the necessary treatment fees. Patients who are not established in the practice will be charged a **$150 after hours emergency fee.**

I agree with the above conditions.

Print Name: _____ Date: _____

Patient/Parent Signature: _____

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HIPPA Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare, operation and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use of disclosure of my health information:

_____
Print Name of Patient or Legal Guardian

_____
Signature of Patient or Legal Guardian

Date:_____

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Consent to Release Information

I authorize Dr. Michael J Young to release medical records to any health care providers participating in my dental care. I also authorize Dr. Michael J Young to release information regarding my dental health or financial information to the following people listed below.

Please indicate your agreement with this policy by signing below.

Patient Name:_____DOB:_____

Signature:_____Date:_____

Release dental information to the following persons.

List name and relationship to patient.

_____

_____

_____

_____

_____