NORTHERN MICHIGAN PEDIATRIC DENTISTRY!

Today's Date _____ Child's Home Phone # _____ Social Security # _____

Child's Name _____ Child's Birth Date ____/____/____ Age _____

Nickname _____ ◯ Male ◯ Female School _____ Grade _____

Child's Home Address: _____
Street City State Zip

Sibling(s) Name(s) _____

Who may we thank for referring you? _____

RESPONSIBLE PARTY/PARTIES

MOTHER/PARENT 1 Birthdate ____/____/____ Home Phone # _____ Cell Phone # _____

Name _____ Social Security # _____

Home Address _____
Street City State Zip

Driver's License or State ID# _____

Employer _____ Work Phone # _____ Ext# _____

Email: _____

FATHER/PARENT 2 Birthdate ____/____/____ Home Phone # _____ Cell Phone # _____

Name _____ Social Security # _____

Home Address _____
Street City State Zip

Driver's License or State ID# _____

Employer _____ Work Phone # _____ Ext# _____

Email: _____

Are the parent(s) married? YES NO IF NOT: Who has guardianship/custody of the child? _____

IF parents are NOT married: Who does the child live with the MOST? _____

DENTAL INSURANCE INFORMATION

Primary Insurance _____ Subscriber's Name _____

INS Identification # _____ INS Group/Plan # _____ INS Phone # _____

Subscriber's Social Security # _____ Birthdate ____/____/____ Relation to Patient _____

Secondary Insurance _____ Subscriber's Name _____

INS Identification # _____ INS Group/Plan # _____ INS Phone # _____

Subscriber's Social Security # _____ Birthdate ____/____/____ Relation to Patient _____

FINANCIAL POLICY AND AUTHORIZATION

Payment or Co-Payment is to be paid in full at each appointment. We accept the following methods of payment: Cash, Money Order, American Express, Visa, Mastercard, Discover Card, CareCredit, & Personal Checks. Driver's License # or State ID # is required to accept payments. I AUTHORIZE all forms of communication with the information I provided to NMPD and its third party affiliates. I authorize the dental staff to perform the necessary dental services my child may need. I authorize the dentist to release all information necessary to secure payment. I authorize my insurance company if being billed by the office to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the use of this signature on all insurance submission. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature of Parent or Guardian _____ Date _____

Northern Michigan Pediatric Dentistry, P.C.

1241 E 8th Street / Traverse City, MI 49686 / (231) 947-4566

IMPORTANT: Please understand, a parent or legal guardian must accompany the patient to the first appointments. Your child's first appointment will consist of a New Patient exam and consultation. Our office will schedule any treatment after this exam. Please bring this completed packet of paperwork, current dental insurance card, and driver's license. If you are more than 10 minutes late, or do not have the paperwork completed, your appointment may be cancelled.

Welcome

INITIAL EACH ↓

Appointment Policy

_____ A parent and or legal guardian must accompany the child to both the new patient and first treatment appointment visits. Doctor approval and written authorization from a parent or legal guardian is required if they are unable to bring to appointment other than listed previously.

_____ If the parent chooses to return to the referring dentist's office rather than continue with 6 month exams and cleanings here, any future referrals will require at least two appointments. The first appointment is for an examination followed by another appointment for any needed work.

_____ ALL FORMS MUST BE FILLED OUT FULLY AND COMPLETELY. Failure to fill out forms with required information that is requested could result in the child/patient not being seen.

_____ OUR OFFICE USES ALL FORMS OF COMMUNICATIONS – mail, phone, text, and email. This can and will be given to 3rd parties we use in form of communication with you, such as but not limited to: notifications, reminders, confirmations, collections, or emergency alerts.

_____ ***I UNDERSTAND I HAVE MEDICAID AND THIS OFFICE DOES NOT BILL TO WITH THE EXCEPTION OF HEALTHY KIDS DELTA DENTAL. IF I HAVE ANY OTHER FORM OF MEDICAID AND I STILL CHOOSE TO HAVE MY CHILD BE SEEN AT NMPD, IT WILL BE AT SELF PAY. (MEDICAID/STATE PROGRAM PATIENTS ONLY)***

Cancellation Policy

There are many times that our patients require urgent or emergency treatment and therefore require an appointment as soon as possible. When patients give the office advance notice of their need to cancel a scheduled appointment, this time can then in turn be allocated to these patients in urgent need of treatment. In this way the office can best serve the needs of ALL patients.

_____ We are committed to your child's dental health. Bearing these special needs in mind, the office requires a minimum of 24-hour notice if an appointment must be cancelled. 24-hour notification is considered business hours meaning any cancellations over the weekend from Thursday night thru the following Monday is not considered a 24-hour notice. If an appointment is missed without any contact or attempt during this allotted time, a letter will be sent to you. The first letter that is sent is a review of this policy. The second letter informs you that you are dismissed from the practice. We understand a child may become sick or unexpected events may result in you not making the appointment. In these cases, please contact the office as soon as possible.

We at Northern Michigan Pediatric Dentistry welcome you to our "family"! We look forward to taking care of your child's oral health needs.

_____ _____

Parent or Guardian Signature **Patient Name** (PLEASE PRINT)

_____ _____

Parent or Guardian Name (PLEASE PRINT) DATE

DENTAL AND MEDICAL HISTORY

Patient Name_____ D.O.B._____
Child's Physician_____ City_____ Phone #_____
Date of Last Physical Exam_____ Results_____
Is the child under the care of a physician now? ☐Yes ☐ No
For_____
Is the child receiving any medication? ☐Yes ☐No
List_____
Last Dentist's Name_____ Phone #_____ Date of Last Visit_____
Has your child had any dental x-rays taken within the last year? ☐ Yes ☐No

Has your child had any history or difficulty with any of the following? If yes, please check or circle.

☐ ADD	☐ Asthma/Breathing Issues	☐ Born Drug/Alcohol Addicted	☐ Spina Bifida
☐ ADHD	☐ Bladder Problems	☐ Epilepsy/Seizures	☐ Kidney/Liver Disease
☐ Apnea	☐ Cancer_____	☐ Fainting	☐ Clenching/Grinding
☐ Anemia	☐ Cerebral Palsy	☐ Hearing Impaired/Deaf	☐ Jaw Pain
☐ Autism	☐ Down Syndrome	☐ Heart Condition	☐ Tooth Injury/Trauma
☐ HIV/AIDS	☐ Sinus Problems	☐ Thyroid Disease	☐ Bleeding Gums/Pain

☐OTHER_____

Ever been treated for Behavioral or Psychological problems?☐ Yes ☐ No
For_____
Ever had Surgery? ☐ Yes ☐ No For_____
Is there excessive bleeding when cut? ☐ Yes ☐ No
Any chance patient may be pregnant? ☐ Yes ☐ No
Does your child need Pre-Medication for a heart condition before dental treatment? ☐ Yes ☐ No
Latex Allergy? ☐ Yes ☐ No List other Allergies_____

EMERGENCY CONTACT INFORMATION

In the event of an emergency, who should we contact?

Name (Not parent)_____ Relationship_____ Phone #_____

Name (Not parent)_____ Relationship_____ Phone #_____

PATIENT CARE POLICY AND AUTHORIZATION

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for my child, and I agree to notify the dentist if any change in my child's health status should occur. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Legal Guardian_____ Date_____

PAYMENT OR CO-PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.

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Written Financial Policy

Thank you for choosing Northern Michigan Pediatric Dentistry, P.C. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable as possible by offering several payment options.

Payment Options Include:

- Cash, Check, Visa, MasterCard, Amex, or Discover Card (all with valid Driver's License)
- NO INTEREST[1] Payment Plans[2] for balances over $200 from **CARE CREDIT** (**must do credit application**)
  Must be present to sign with two forms of identification
  - Care Credit allows you to pay over time with NO INTEREST[1] **"IF"** paid in **promotional time**
  - Care Credit offers convenient, low monthly payment plans[2] also available
  - Care Credit has no annual fees or pre-payment penalties

Please Note:

Northern Michigan Pediatric Dentistry, P.C. requires estimated co-payment **AT TIME OF SERVICE**. A $10.00 Delay of Payment Fee will apply to the account if any balance is NOT paid at the time of service. Three times (3x) without paying at time of service will be a dismissal from the practice. As a courtesy, we do file a Pre-Determination for treatment to your dental insurance to get the estimated insurance portion for you. It becomes the patient's (parent/guardians) responsibility to cover procedures that are not covered by their insurance plan including ALL limitation policies. Not all services are covered by your insurance carrier and every insurance plan has its own unique "quirks" & exceptions. As a policy holder, it is ***YOUR*** responsibility to know your plan AND know and watch your plan limitations. WE ONLY USE COMPOSITE (WHITE) FILLINGS IN OUR OFFICE. You will incur an out-of-pocket expense if your insurance company reimburses at an amalgam (silver) filling rate. Contact your insurance carrier with any questions regarding your plan's benefit and limitations.

For patients with dental insurance that we bill to, we are happy to work with your carrier to maximize your benefit and as a courtesy we will directly bill them for reimbursement for your treatment. However, if we do not receive payment from your insurance carrier w/in 30 days, you will be responsible for payment of your treatment fees and possibly getting collection of your benefits directly from your insurance carrier. If the account is not paid in full by 60 days from date of service, texts, email if available, a letter, and/or possibly a call/calls will be made before collection/court proceedings begins. A Billing Charge of $5.00 will apply to ALL statements that are sent. In the event of collection action, debtor agrees to pay all collection cost 28%, including reasonable attorney fees or additional costs associated in efforts of collecting or obtaining this debt. As an office policy, we do require a Social Security Number (SSN) for ALL policy holders AND guarantors (Responsible Party). Responsible party is determined by who brings the child to the first visit & signs forms. A copy of their ID will be required. NMPD is ONLY IN NETWORK with Delta Dental Premier plans and the Careington Platinum network. We participate with some BCBSM plans and some Delta PPO plans. This is dependent on your individual plan. We do bill to other insurance companies but they will be out of network & you will be responsible for anything your insurance does NOT cover.

You agree, in order for us to service our account or to collect any amount you may owe, NMPD and associated 3rd parties of NMPD may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provided to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. You DO specifically consent to receive telephone calls, short messages services, text messages, or other messages made or delivered to the telephone numbers that were provided. That you acknowledge that these calls may be made or delivered using an automatic dialing system and/or an artificial or pre-recorded voice, made by the Center or its business associates for purposes of treatment, payment, and health care operations.

We are NOT responsible nor do we follow any parental agreements of percentage/or other party co-pays in separated families unless a copy of a court documented divorce decree is provided stating the office must take those percentages. It is a responsibility and an expectation that all balances will be paid at time of service by whomever brings them or if not paid then ultimately by the responsible party of said balance and if additional monies are needed. Any balances will default to the guarantor on the account.

No appointments will be made if there is a balance on the account for patient or any members of their family. We are unable to accept post-dated checks. Northern Michigan Pediatric Dentistry, P.C. charges $35.00 for returned checks. You may no longer be able to use this form of payment for future visits.

**If you have any questions, please do not hesitate to ask and we will do our best to help.

_____

Parent or Guardian Signature Date

_____

Parent/Guardian Name (Please Print)

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required. [2]Subject to credit approval

Northern Michigan Pediatric Dentistry, PC
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James M Van Wingen, DDS, MS
Brandon D. Boike, DDS
1241 E 8th Street
Traverse City, MI 49686
Fax: 231-947-9873
Email: info@secure.nmpdkids.com

I authorize the person(s) listed below, **in addition to the parent / legal guardians** to take my child to the above-named providers for treatment. I authorize the administration of measures as are deemed necessary for those appointments.

I hereby give permission to consent and authorize the names below to act on my behalf. I give them my permission to bring my child, to discuss, and to make dental decisions in all matters of the child. This includes but is not limited to making appointments, discussion of financial information, and authorizing of any form of treatment.

By listing the adults below, I authorize the staff of Northern Michigan Pediatric Dentistry to disclose any protected health information as needed to facilitate the dental care of my child. If you do not want anyone else to bring your child please write "none" and sign and date the bottom. This is active and current until I provide information in writing stating otherwise.

Name	Relationship to Child	Phone Number

Parent/Legal Guardian Signature_____ **Date**_____

Parent/Legal Guardian Printed Name_____ **Patient Name**_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization In refusing we may not be allowed to process your insurance claims

Date:_____Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____

Name: _____ Relationship: _____

✓ I AUTHORIZE CONTACT FROM THIS OFFICE OR THEIR 3RD PARTIES THEY USE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION\NOTIFICATIONS USING ALL FORMS OF COMMUNICATIONS** VIA MAIL/PHONE/TEXT/AND EMAIL WITH THE INFORMATION I PROVIDE TO THE OFFICE.

✓ I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED USING ALL FORMS OF COMMUNICATIONS VIA MAIL/PHONE/TEXT/AND EMAIL WITH THE INFORMAITON I PROVIDE TO THE OFFICE.

✓ I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO on behalf of this Healthcare Facility via ALL FORMS OF COMMUNICATIONS VIA MAIL/PHONE/TEXT/AND EMAIL WITH THE INFORMATION I PROVIDE TO THE OFFICE.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please *print* name of Patient Please *sign* Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

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OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)_____

Signature of Privacy Officer _____