NemetzDentalAssociates
SPECIALTY DENTAL CARE FOR THE ENTIRE FAMILY
Pediatric Dentistry • Adult Dentistry • Periodontics • Prosthodontics

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Board Certified Pediatric Dentist

Phone (904)292-2210
www.nemetzdental.com

ORAL HEALTH FORM

We welcome your child into our practice with the goal to make his/her experience very pleasant. Please complete this form thoroughly because the information is of great value in helping us to better understand and care for your child.

Child's Name _____ _____ Male_____ Female_____ Date_____

What is your child's nickname_____ Date of Birth _____ _____ Weight _____

Name and ages of brothers and sisters _____

Child's Physician or Pediatrician_____

Physician's phone # _____ _____ Family Dentist _____

What school does your child attend? _____ How did you hear about us? _____

Name of child's favorite pet, toy, hobby or sport activity? _____

What is your Main Concern , if any about your child's mouth or teeth? _____

HEALTH HISTORY

HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING (PLEASE CHECK):

☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Tuberculosis	☐ Vision Disorder	☐ Hearing Disorder
☐ Sinus Problems	☐ Convulsions	☐ Kidney Disorder	☐ Lung Disease	☐ Bladder Disease	☐ Bleeding Disorder
☐ Cleft lip/ palate	☐ AIDS	☐ Malignancy	☐ Liver Disease	☐ Heart Disorder	☐ Thyroid Disorder
☐ Blood Transfusion	☐ Blood Disorders	☐ Anemia	☐ Epilepsy	☐ Cerebral Palsy	☐ Psychiatric treatment
☐ Rheumatic Fever	☐ Developmental Disability		☐ Other _____		

	YES	NO
1. Does your child have a health problem?	____	____
2. Is your child under the care of a physician now? For illness or injury?	____	____
3. Has you child had an unexplained weight loss in the last 12 months?	____	____
4. Is your child taking any medicine or drugs?	____	____
If yes, what medications? _____		
5. Does your child have any swollen glands or lymph nodes?	____	____
6. Does your child have or has he/she had frequent ear and throat infections or tubes in ears?	____	____
7. Has your child any history of hearing loss or speech problems?	____	____
8. Is there excessive bleeding when cut?	____	____
9. Has your child ever been hospitalized?	____	____
10. Has your child ever had surgery?	____	____
11. Is there any allergy or unfavorable reaction to antibiotics (e.g. Penicillin), local anesthetics or other drugs?	____	____
If yes, please specify _____		
12. Are there other allergies: food, pollen, animals, dust, other?	____	____
13. Is there any other information I should be aware of that is not mentioned above?	____	____
Please describe: _____		

DENTAL AND FAMILY HISTORY

	YES	NO
1. Has your child any history of nail biting, thumb sucking, finger sucking, mouth breathing, teeth grinding or did he/she use a pacifier past age1 ½ years? (Please circle the condition)	____	____
2. Is this a currently active habit?	____	____
3. Has mother or father had a lot of tooth decay?	____	____
4. In your family, is there any history of malocclusion, bad bites, missing or extra teeth?	____	____
Please explain _____		
5. Has your child had a toothache recently?	____	____
6. Is your child in pain now?	____	____
7. Do you think there is anything wrong with his/her teeth, such as chipping, decay, gum boil, etc.....	____	____
Please explain _____		
8. Has your child had previous dental treatment?	____	____
When and where? _____		
9. Have you been satisfied with your child's previous dental care?	____	____
10. If you have previously completed this form for another child, please give that child's name _____		

Father/ Guardian Name: _____ Mother's Name: _____

Driver's Lic. #: _____DOB: _____ Driver's Lic. #: _____DOB _____

Soc. Sec. # _____ Home Phone_____ Soc. Sec. # _____Home Phone_____

Work Phone_____ Cell Phone_____ Work Phone_____ Cell Phone_____

Home Address_____ Home Address_____

_____ _____

Mailing address if different from home address _____

Father Employed by _____

Occupation _____

Business Address _____Phone _____

Street City State Zip

Mother Employed by _____

Occupation _____

Business Address _____Phone _____

Street City State Zip

In case of emergency, Name of nearest relative or friend: _____Phone _____

Dental Insurance Information

Insurance Company Name:_____

Insurance Company Address:_____ _____

Insurance Company Phone#:_____ _____

Group/Policy#_____ _____

Insured's Name:_____

Insured's Birthdate:_____ _____

Insured's Employer:_____ _____

Because your child is a minor, it is necessary that signed permission be obtained from a parent or guardian before any/or all dental treatment is performed. Diagnosis of services needed and financial obligations will be discussed with you by the doctor and/or staff before treatment is rendered. Your signature authorizes the Dentist to render dental treatment, to administer medications, to administer anesthetics, to take radiographs (X-Rays), clinical photographs, study models, and other records necessary for an accurate diagnosis and to utilize behavior management therapy as needed to provide safe dental care for your child and to employ such assistance as is appropriate.

The undersigned also agrees to be responsible for any bill incurred on this child for dental treatment.

NAME _____ **DATE** _____

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Consent

I hereby grant authority to Dr. Nemetz and her legally qualified auxiliaries to utilize x-rays, anesthetics, pre-medications, preventative and restorative procedures as may be necessary or advisable in the diagnosis and treatment of my child's dental condition. I understand that I will be consulted before any treatment is rendered.

_____	_____	_____
Childs Name	**Parents Signature**	**Date**

Missed/Broken Appointments

I understand that a minimum of 24 hours notice is required to cancel or reschedule all dental appointments. I also understand that a $50.00 broken appointment fee will be applied to my account if the cancellation occurs without 24 hours advance notice, and I agree to remit the fee within one week of the broken appointment. (*Allowances may be made for illness or injury*)

_____	_____	_____
Childs Name	**Parents Signature**	**Date**

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Separation Agreement

Many parents ask "Can I stay with my child during their dental visit?"

We ask that you allow your child (over the age of 3) to accompany our dental staff through their dental visit if they are not highly anxious or fearful. We are experienced in helping children overcome anxiety. Separation anxiety is not uncommon in children; this is normal and as time passes and the more familiar your child becomes with our staff during their dental visit these feelings of anxiety will diminish. Studies and experience have shown that most children over the age of 3 react more positively when permitted to experience the dental visit on their own and in a friendly environment designed for children.

We will be happy to give you updates during your child's visit and we will invite you back to discuss your child's exam and progress in their oral health. We strive to develop a positive relationship with your child so that they look forward to their next dental visit.

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FINANCIAL POLICY FOR PATIENT'S AND DEPENDANTS

This financial policy is provided to help you understand the financial aspects of your visit to our office. Dentistry is no different than any other service oriented business. Payment is due when services are rendered. We do not participate with all insurance companies. If you provide us with your current insurance information, we will file claims to your primary insurance carrier for you. *This office will not file your secondary insurance. We will provide you with claim forms, if necessary, that you can use to file a claim to your secondary insurance.* We can provide you with a written estimate for any planned dental procedures. This estimate will include the anticipated procedures needed and the cost of those procedures. The written estimate will show you an approximate breakdown of how your insurance company may apply your dental benefits to the planned treatment. This estimate may change after the treatment begins based upon the clinical findings of the doctor during the course of care. Please keep in mind, that the estimate includes only approximate figures and we cannot exactly predict how your insurance company will reimburse for each procedure. The fees listed on the estimate are good for 120 days and are subject to change thereafter. You are ultimately 100% responsible for the entire amount of any treatment completed if your insurance company fails to pay their portion of this estimate. Communication between you and your insurance company is highly encouraged to ensure timely insurance processing and payment. During the course of dental care at this office, if you sign up with a different dental insurance carrier with your employer you may incur additional charges at this office depending on your benefits. It is important for all patients to understand the terms and conditions of their insurance policies. Unlike medical insurance, most dental insurance companies have annual maximum benefits that significantly limit the amount of dental coverage especially if your dental needs are extensive. If your dental needs exceed your annual maximum benefits, you will be financially responsible for the remaining balance.

We have excellent relationships with many insurance companies but we have no way of knowing any limits you may have reached or any remaining balances that will be applied towards your deductible. Some insurance companies may deny benefits for routine dental procedures. If there is a problem with one of your claims, we will do everything possible to get your insurance company to pay their portion of the claim. If they continue to deny the claim, you will be responsible for payment of the entire amount. Please remember, your employer customizes insurance plans and they may limit certain items such as frequency of exams, x-rays or certain types of restorations. It is important for you to understand what your plan will pay. We will do everything we can to make sure your insurance company has accurate information they need to process your claim. However, please remember that we are not responsible for denied claims or restrictions of your insurance benefits. You will be responsible for any remaining balance that is not covered by your insurance company. By filing your insurance, we are extending credit to you from the time treatment begins to the time the insurance payment is received. Generally, this may be up to 60 days. However, if after 60 days ,from the date of service, your insurance company has not paid your claim, we will forward the unpaid balance directly to you for payment. Rebilling charges will begin to accrue at 90 days on unpaid balances, at the rate of 1.5% per month until paid in full.

Any long-standing unpaid balance that has not been paid by the patient or by the dental insurance company will be sent to a collection agency. Along with interest charges, additional surcharges of up to 35% of the total unpaid balance plus collection agency processing fees will be added to your balance. You are responsible for any collection agency or legal fees associated with the collection of an unpaid balance. To avoid this collection process, please pay off your balance promptly. Please understand that in order for us to file your insurance and to provide services in advance of payment, we must set these policies. We value you as a patient and look forward to a long-term and rewarding relationship.

If you do not have dental insurance, payment is expected when dental services are rendered. A low interest third party credit payment plan is available to qualifying patients. Please ask one of our office staff to assist you with this simple application process.

I have read the above information and understand that I am responsible for any unpaid balance for services provided to my dependent or me.

Name_____ **Date**_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A. PATIENT CONSENT

Name: _____

Address: _____

Telephone: _____ E-Mail Address: _____

Social Security #: _____

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you Decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent at our office. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those Changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: (904) 292-2210 Fax: (904) 292-2205
Address: 12421 San Jose Blvd. Suite 320 Jacksonville, FL 32223

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that the revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Signature:
I, _____ have had full opportunity to read and consider this consent
Parent or Guardian Print Name

form and the Notice of Privacy Practices. I understand that by signing this Consent form I am giving my consent for the use and disclosure of my protected health information and to carry out treatment, payment activities and health care operations.

Parent or Guardian Signature: _____

Relationship to Patient: _____