Smile Galaxy
PEDIATRIC DENTISTRY

PATIENT REGISTRATION

TELL US ABOUT YOUR CHILD

Child's Name _____
First Middle Initial Last

Nickname _____ ☐ Male ☐ Female

Child's Birthdate ____/____/____ Child's Age _____

Child's Home Address _____

City, State, Zip _____

How did you choose our office? _____

MOTHER'S INFORMATION

☐ **Mother** ☐ **Stepmother** ☐ **Guardian** ☐ **Foster Parent**

Name _____

Address _____

Address Cont'd _____ Home Phone ( ) _____

Cell Phone ( ) _____ Work # _____

Birthdate ____/____/____ SSN# _____

Employer _____

Email Address _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Do you have legal custody of this child? ☐ Yes ☐ No

FATHER'S INFORMATION

☐ **Father** ☐ **Stepfather** ☐ **Guardian** ☐ **Foster Parent**

Name _____

Address _____

Address Cont'd _____ Home Phone ( ) _____

Cell Phone ( ) _____ Work # _____

Birthdate ____/____/____ SSN# _____

Employer _____

Email Address _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Do you have legal custody of this child? ☐ Yes ☐ No

OTHER CHILDREN BEING SEEN AT OUR OFFICE

Name _____ DOB ____/____/____

Name _____ DOB ____/____/____

Name _____ DOB ____/____/____

Will someone other than this child's legal guradian be bringing this child to future appointments? (ie grandparents, etc.)

☐ **Yes** ☐ **No** Name _____

Relationship _____

Would you like to receive appointment reminders? ☐ Mom ☐ Dad

via ☐ ***Text Message*** ( ) _____ ☐ ***Email***

EMERGENCY CONTACT OTHER THAN LEGAL GUARDIAN

Name _____ Relation _____

Best Phone # ( ) _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone # ( ) _____

Policy # _____ Group # _____

Local # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____ SSN# _____

Policy Owner's Employer _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone # ( ) _____

Policy # _____ Group # _____

Local # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____ SSN# _____

Policy Owner's Employer _____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to the doctors at Smile Galaxy Pediatric Dentistry, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. ***I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental insurance. My part of the expenses will be due today or at the time services are rendered.***

Signature of Parent/Guardian _____ Print Name _____ Date _____

SmileGalaxy
PEDIATRIC DENTISTRY

PATIENT NAME _____

DATE OF BIRTH _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that your child may have or have had in the past, or medication that he/she may be taking, could have an important interrelationship with the dentistry he/she will receive. Thank you for answering the following questions with diligence and accuracy.

Is your child under a physician's care other than his/her PCP?	○Yes ○No	*If yes, explain*
Has your child ever been hospitalized or had an operation?	○Yes ○No	*If yes, explain*
Has your child ever had a serious head injury?	○Yes ○No	*If yes, explain*
Is your child taking any medications?	○Yes ○No	*If yes, explain*
Is your child on a special diet?	○Yes ○No	*If yes, explain*
Does your child use tobacco of any kind?	○Yes ○No	*If yes, explain*
Does your child vape?	○Yes ○No	*If yes, explain*

Is your daughter...

Pregnant/Trying to get pregnant? ○Yes ○No Nursing? ○Yes ○No Taking oral contraceptives? ○Yes ○No

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin/Amoxicillian ☐ Codeine ☐ Acrylic ☐ Augmentin
☐ Metal ☐ Latex ☐ Sulfa drugs ☐ Local Anesthesia ☐ Clindamycin
☐ Zithromax ☐ Other _____

Does your child have or have they had any of the following?

AIDS/HIV Positive	○Yes ○No	Cortisone Medicine	○Yes ○No	Hepatitis A	○Yes ○No	Renal Dialysis	○Yes ○No
ADD	○Yes ○No	Diabetes	○Yes ○No	Hepatitis B or C	○Yes ○No	Rheumatic Fever	○Yes ○No
ADHD	○Yes ○No	Drug Addiction	○Yes ○No	Herpes	○Yes ○No	Rheumatism	○Yes ○No
Anaphylaxis	○Yes ○No	Easily Winded	○Yes ○No	High Blood Pressure	○Yes ○No	Scarlet Fever	○Yes ○No
Anemia	○Yes ○No	Emphysema	○Yes ○No	High Cholesterol	○Yes ○No	Shingles	○Yes ○No
Angina	○Yes ○No	Epilepsy or Seizures	○Yes ○No	Hives or Rash	○Yes ○No	Sickle Cell Disease	○Yes ○No
Arthritis/Gout	○Yes ○No	Excessive Bleeding	○Yes ○No	Hypoglycemia	○Yes ○No	Sinus Trouble	○Yes ○No
Artificial Heart Valve	○Yes ○No	Excessive Thirst	○Yes ○No	Irregular Heartbeat	○Yes ○No	Spina Bifida	○Yes ○No
Artificial JointAsthma	○Yes ○No	Fainting Spells/Dizziness	○Yes ○No	Kidney Problems	○Yes ○No	Intestinal Disease	○Yes ○No
Austistic	○Yes ○No	Frequent Cough	○Yes ○No	Leukemia	○Yes ○No	Stroke	○Yes ○No
Blood Disease	○Yes ○No	Frequent Diarrhea	○Yes ○No	Liver Disease	○Yes ○No	Swelling of Limbs	○Yes ○No
Blood Transfusion	○Yes ○No	Frequent Headaches	○Yes ○No	Low Blood Pressure	○Yes ○No	Thyroid Disease	○Yes ○No
Breathing Problem	○Yes ○No	Genital Herpes	○Yes ○No	Lung Disease	○Yes ○No	Tonsillitis	○Yes ○No
Bruise Easily	○Yes ○No	Glaucoma	○Yes ○No	Mitral Valve Prolapse	○Yes ○No	Tuberculosis	○Yes ○No
Cancer	○Yes ○No	Hay Fever	○Yes ○No	Osteoporosis	○Yes ○No	Tumors or Growths	○Yes ○No
Chemotherapy	○Yes ○No	Heart Attack/Failure	○Yes ○No	Pain in Jaw Joints	○Yes ○No	Ulcers	○Yes ○No
Chest Pains	○Yes ○No	Heart Murmur	○Yes ○No	Parathyroid Disease	○Yes ○No	Vision Problems	○Yes ○No
Cold Sores/Fever Blisters	○Yes ○No	Heart Pacemaker	○Yes ○No	Psychiatric Care	○Yes ○No	Venereal Disease	○Yes ○No
Congenital Heart Disorder	○Yes ○No	Heart Trouble/Disease	○Yes ○No	Radiation Treatments	○Yes ○No	Yellow Jaundice	○Yes ○No
Convulsions	○Yes ○No	Hemophilia	○Yes ○No	Recent Weight Loss	○Yes ○No		

If yes to heart murmur, does your child need a pre-medication for dental treatment? ○Yes ○No *If yes* _____

Does your child have a genetic disoreder? ○Yes ○No *If yes* _____

Does your child have a syndrome/disease? ○Yes ○No *If yes* _____

Has your child ever had any serious illnesses not listed above? ○Yes ○No *If yes* _____

COMMENTS

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform Smile Galaxy of any changes in my child's medical status.

Signature of Parent or Guardian (or Patient if 18yo+) Date

Patient(s) Name:

Please initial that you have read and understand each section.

_____**Financial Policy**

I have received the Smile Galaxy Financial and Insurance policy that outlines my financial responsibility toward care rendered by the doctors at Smile Galaxy Pediatric Dentistry (SGPD). **I understand that the parent or legal guardian who accompanies my child to an appointment will be responsible for payment at the time services are rendered.**

_____**Appointment Cancellation or No-Show Policy**

I take full responsibility for the cancellation/rescheduling of any needed appointments. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, **WE REQUIRE AT LEAST A 24hr NOTICE PRIOR TO YOUR APPOINTMENT TIME to avoid a cancellation fee**. Many patients are waiting months in advance for appointments, please respect our schedule and our other patients by giving us time to fill your reserved spot with another patient in need of care. **Should a patient fail to keep a surgery appointment a $200 fee will be charged if advance notice is not given** so that appointment may be given to another child in need of treatment. Should no advance notice of cancellation be given, SGPD reserves the right to dismiss the patient from the practice.

_____**Medical / Dental Release Statements**

As the birth/adoptive parent or legal guardian, I give my consent for the doctors of *Smile Galaxy Pediatric Dentistry* to complete a thorough examination on the patient named above including any needed diagnostic radiographs. To the best of my knowledge the information I have provided is accurate and I understand that it will be held in the strictest of confidence and in accordance to all federal and state HIPAA regulations. Further more, I understand that it is my responsibility to inform *SGPD* of any future changes to my child's medical history status. As a parent or legal guardian of the previously named patient, I also hereby grant the doctors and staff of *SGPD* permission to perform future treatment(s) as deemed appropriate. I understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time services are rendered, unless prior arrangements have been approved.

_____**Insurance Claim Release & Financial Responsibility Statement**

To precipitate the filing of this and all future dental insurance claims, I do hereby authorize the release of confidential information to my child's dental insurance company. I am aware that *SGPD* will be providing an estimate of the insurance coverage prior to initiating any future treatment and that I am legally responsible for any portions not paid by this policy. I understand that additional out-of-pocket expenses may be accrued should estimates provided by my insurance company be inaccurate or should procedures change during the course of the treatment. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 45 days of receiving such treatment.

_____**Authorization for Direct Payment**

I hereby authorize payment of insurance benefits directly to *SGPD* or the dentist that performs treatment on my child. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

_____**Notice of Privacy Practices,** Health Insurance Portability & Accountability Act of 1996

I have read the form entitled, "Notice of Privacy Practices," and understand its contents concerning the privacy of my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Smile Galaxy Pediatric Dentistry from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

I have read and understand the above policies.

Parent or Legal Guardian Signature **Date**

Smile Galaxy Employee Signature

Financial Policy and Insurance Information

Methods of Payment.
For your convenience we accept cash and all major credit cards (Visa, MasterCard, American Express and Discover Card). **Sorry, no personal checks will be accepted.**

As we strive to be one of Oklahoma City's leading providers for pediatric dental care, we work to assist parents in taking an active role in their child's dental health. Because we value our relationship with you and believe that the best relationships are based upon understanding, we offer these clarifications on methods of payment & insurance reimbursement.

At each visit, we will request a copy of your dental insurance information to allow us to file your claim. Please remember to bring all dental insurance information/insurance card(s) to each appointment. Please contact SGPD immediately after making any changes to your dental coverage, so we can keep our records current and to provide expeditious reimbursement of your benefits.

If any treatment needs are discovered during your child's exam, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out-of-pocket portion for the treatment plan. We will discuss all treatment options and costs before beginning any further treatment. We know that dental insurance can be confusting, so feel free to contact us with insurance or payment questions.

Dental Insurance

We are dedicated to providing all our patients with the best treatment available and base all our treatment recommendations on what will be best for your child and not what your insurance company does or doesn't pay. Please note the following in regards to your dental insurance coverage:

1. We must emphasize that as a health care provider, *our relationship is with you* and not your dental insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Most plans routinely pay between 50-75% of the average total fee for a given procedure. This percentage is pre-determined by the plan your employer has purchased.
2. As a courtesy, we will be happy to file for your insurance benefits. Because your dental insurance plan is a contract between you, your employer, and the insurance company, many carriers will not reimburse our office. **In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.**
3. **Any amount not covered by your insurance company is payable at the time services are rendered**; these fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. Unfortunately, some of the services that we may recommend for your child may not be covered by your specific dental insurance. Our primary goal is to treat your child using the best possible materials, supplies, medications and environment.
4. We allow a maximum of 45-days for your insurance company to clear account balances. **Any unpaid portions will be due in full, by you, after this period**. If you have not paid your balance within 60 days of the date treatment was rendered a finance charge of 1.5% will be added to your account each month until paid. Should your insurance company submit payment after this time, we will be glad to reimburse you. This is rare but is important that you recofgnize that your insurance 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.
5. Our office does not determine your dental benefits. Your employer chooses your particular policy. If you are unhappy with it's coverage, this should be mentioned to your employer's benefits coordinator. Only your employer can adjust benefits.

Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out-of-pocket portion (*estimated patient portion or EPP*). *Please remember, this is only an estimate based upon generalized information provided by your dental insurance company*. An additional billing or possibly a refund may be subsequently required should information provided be inaccurate.

We will always do our best to maximize the insurance benefits that you are eligible to receive and we appreciate your prompt settlement of any charges that may be incurred during the treatment process. We look forward to years of close association with you, as we work together to maintain your child's oral health!

How Dental Insurances Actually Work

For starters, there are no perfect dental insurance policies. Even in the best possible scenario, dental insurances will cover only 50-75% of *certain* dental treatments. This percentage is based upon how much your employer has provided to its employees for this specific benefit. *Smile Galaxy Pediatric Dentistry* has no control over how an insurance policy provides coverage for treatment. Should you be unhappy with your particular coverage, please contact your employer's human resource department to inquire about possible policy changes or upgrades.

After the treating doctor establishes a treatment plan for your child, an office administrator will then thoroughly review the doctor's recommended treatments, answer any clinical or financial questions and will present your expected financial obligation. An "EPP" or *estimated patient portion* will be presented to you, which is the anticipated amount that you will be responsible for and is based upon the latest information provided by your insurance company regarding your particular policy. However, this amount is *strictly an estimate and very often is not what they will inevitably pay*. Insurance companies refuse to provide dentists with the exact amount they will pay for a procedure, as they maintain the ability to sporadically change their coverage in order to manage their company's overhead. It is also important to understand that most policies have specific dental procedures that they will simply *not cover at all*. Should your particular policy not cover our provided treatments in the manner that we presented during the diagnostic phase of treatment, we apologize in advance and ask for your understanding, as we are, unfortunately, limited by how precise our estimates can be. Very often our estimates are correct or very close, but regrettably, insurance companies are deliberately deceptive during this process, which makes it impossible to obtain an exact, up-to-date amount until only after the claim has been processed. Because of this, you can expect to receive an updated billing statement from our office after your insurance company has paid its portion. This bill will be sent approximately 4-12 weeks after your visit, as insurance companies tend to take an extended period of time to settle such claims. We appreciate you settling such remaining balances expeditiously.

At *Smile Galaxy Pediatric Dentistry*, we always try to work within the boundaries established by your specific dental policy, but feel it is our ethical duty to present recommendations based upon what is truly best for your individual child, regardless of your policy's specific coverage. Should the financial burden of a recommended treatment be a burden, please feel free to inquire about any possible alternative treatments that may be covered by your particular policy. The treating doctor or treatment coordinator will review these possible options, if any exist.

As a courtesy to our patients & parents, we will file your insurance claims on your behalf. Though many local dental providers require patients pay the full amount for treatment in advance and ask that they file their own claim, we believe that this can cause much confusion and heartache for you. In so, we are happy to complete this arduous step for you and appreciate your help in maintaining accurate and up-to-date information regarding your particular policy.

As always it is our highest goal to provide you and your family with the best treatment and service possible. Please feel free to contact us with any dental insurance questions or concerns and a financial coordinator will be happy to help with this sometimes-confusing subject.

I have read the previous information regarding dental insurance and my financial responsibility towards care rendered at Smile Galaxy Pediatric Dentistry. I understand that the parent or guardian who accompanies my child will be held responsible for payment at the time services are rendered, unless prior arrangements have been made. Furthermore, I understand that estimated patient portions presented during the examination phase of treatment may be inaccurate and that I am personally responsible for any additional amounts remaining on this account after insurance claims have been paid-in-full.

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PEDIATRIC DENTISTRY