UPDATED INFORMATION AND OFFICE POLICIES

Patient's Name: ____ **DOB: ___________**

Print Parent Name: ______________________________________ **Relationship to Patient: _____________**

Parent/ Guardian Signature: _______________________________ **Today's Date: ____________**

Home Address: ________________________________ City: ________________ State: ______ Zip: ___________

Parent Email: ____ **Home Phone: __________________________**

Parent 1 Cell: _________________________________ **Parent 2 Cell: __________________________________**

PLEASE READ - Most insurance companies pay on a percentage basis, such as 100% for preventive, 80% for basic, and 50% for major services. Some insurance have various frequencies for procedures, and some are **not** covered by insurance. **NOT ALL SERVICES ARE A COVERED BENEFIT**. Any services **not** covered will be the **patient's/parent's responsibility**. You, the member, need to fully understand these terms and agreements with your own dental insurance company. **YOU, THE MEMBER, WILL THEN BE RESPONSIBLE FOR ANY DEDUCTIBLE AND/OR COPAYMENTS** up to 100% of the maximum allowable fee set by your insurance at the time treatment is rendered. We must emphasize that as dental care providers, our relationship is with you and not your insurance company. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask - we are here to help you. **Please look at your EOB (explanation of benefits) that is mailed to you.** ****FOR DUAL INSURANCE COVERAGE** - **MUST provide the EOB of the primary insurance within 30 days** of receipt, or you will be responsible for any remaining balance on the account. **INITIALS: __________**

CHARGES MAY ALSO BE INCURRED FOR BROKEN OR CANCELLED APPOINTMENTS: Kids Dental, P.C. is committed to providing quality specialized dental care. We ask that you please be respectful of the time that is scheduled for your appointment(s). Our policy requires that you give us, at minimum **24 hours** notice (not including weekends and holidays) if you need to cancel or reschedule your appointment. Failure to do so will result in a **$30.00** fee for HYGIENE appointments and **$50.00** fee for your DOCTOR appointments. If you arrive 15 minutes, or more, late for your appointment, your appointment may have to be rescheduled. **INITIALS**: __________

CREDIT CARD AUTHORIZATION: It is our OFFICE POLICY to obtain your credit card information and authorization to process a claim for payment should your dental health insurance not honor the claim submitted or you have a remainder out of pocket. In providing credit card information below, you **authorize payment by credit card** for services in the absence of coverage by your dental insurance (including, but not limited to, **copayments, deductibles, and/or not covered services), missed appointment fee, and/or bounced checks that cannot be redeposited, and associated bank fees**.

Name on Credit Card ____ **Billing Zip Code _____________**

Credit Card Number (Visa/MC) ___________________________________ **CVV/CID _________** **Exp. Date _______**

Signature ____ **Today's Date _______________**