

11649 N Port Washington Rd, Suite 112
Mequon, WI 53092

Guardian Information

Name: _____
Birthday: _____
SSN: _____
Home Address: _____
Phone: _____
Email: _____

Insurance Patient

Insurance Subscriber Name, Birthday, and SSN:

Insurance Company: _____
Subscriber ID: _____

Self Pay Patient

Patient History

Name: _____
Birthday: _____
Gender: _____
Form completed by: _____
Relationship to child: _____
Date completed: _____

HOUSEHOLD:

Please list all those living in the child's home:

Name	Relationship to child	Birthday	Health Problems

GENERAL HEALTH:

Do you consider your child to be in good health? ___ Yes ___ No
If no, why? _____
Does your child have any serious illness or medical conditions: ___ Yes ___ No
If yes, what? _____

Has your child had serious injuries or accidents? ____ Yes ____ No

If yes, what and when? _____

Has your child had any surgery? ____ Yes ____ No

If yes, what and when? _____

Has your child ever been hospitalized? ____ Yes ____ No

If yes, why and when? _____

Is your child allergic to any medicines or drugs? ____ Yes ____ No Please List:

Does your child have any allergies? ____ Yes ____ No

If yes, what? _____

DEVELOPMENT:

Are you concerned about your child's physical development? ____ Yes ____ No

Explain _____

Are you concerned about your child's mental or emotional development? ____ Yes ____ No

Explain _____

Are you concerned about your child's attention span? ____ Yes ____ No

Explain _____

Has your child failed or repeated a grade in school? ____ Yes ____ No

Explain _____

If your child is in school: How is his/her behavior in school?

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

PATIENT HEALTH HISTORY:

Does your child have, or has ever had any of the following past or present?

Chickenpox: Yes ____ No ____ When _____

Frequent ear infections: Yes ____ No ____ Explain _____

Problems with ears or hearing: Yes ____ No ____ Explain _____

Nasal allergies: Yes ____ No ____ Explain _____

Problems with eyes or vision: Yes ____ No ____ Explain _____

Asthma, bronchitis, bronchiolitis, pneumonia: Yes ____ No ____ Explain _____

Any heart problem or heart murmur: Yes ____ No ____ Explain _____

Anemia or bleeding problems: Yes ____ No ____ Explain _____

Anxiety or Depression: Yes ____ No ____ Explain _____

ADD/ADHD: Yes ____ No ____ Explain _____

Blood transfusions: Yes ____ No ____ Explain _____

Frequent abdominal pain: Yes ____ No ____ Explain _____

Constipation requiring doctor visits: Yes ____ No ____ Explain _____

Bladder or kidney infections: Yes ____ No ____ Explain _____

Bed-wetting (after 5 y.o.): Yes ____ No ____ Explain _____

(For girls) has she started menstrual period? Yes ___ No ___ When _____
 (For girls) are there problems with period? Yes ___ No ___ Explain _____
 Any chronic or recurrent skin problems (Acne, eczema, etc.)? Yes ___ No ___ Explain _____
 Frequent headaches: Yes ___ No ___ Explain _____
 Convulsions or other neurologic problems: Yes ___ No ___ Explain _____
 Diabetes: Yes ___ No ___ Explain _____
 Thyroid or other endocrine problems: Yes ___ No ___ Explain _____
 Use of alcohol or drugs: Yes ___ No ___ Explain _____
 Any other significant problem: Yes ___ No ___ Explain _____

DENTAL HEALTH HISTORY

Has your child had cavities before? ___ Yes ___ No
 If yes, when? _____
 Does your child complain of dental pain? ___ Yes ___ No
 Explain _____
 Is there a specific reason for your visit today?

Office Policies

- Payments * by checking you are initialing * - Payment is expected the day services are rendered. In the event of a default of payment or any balance not covered by insurance that is 90 days past due, your account will be turned over to our collection agency. The responsible party will pay all reasonable court costs and attorney fees. We are sensitive to the fact that some patients may not be able to pay cash for their treatment: therefore, we do offer several alternative payment programs for your convenience, including, Check, Credit Cards (MasterCard, Visa, Discover, and American Express), Care Credit (Healthcare financing option) some plans with no interest. Please not any balances that are over 30 days past due will accrue a 1.0% interest fee. I understand that any fee estimate for this dental care can only be extended for six (6) months from the date of the patient's examination. In consideration for the professional services rendered to me by this practice, I agree to pay for the charges for the services at the time of treatment or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to by me in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if a suit is instituted hereunder. I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment.

- Insurance - * by checking you are initialing * - If you have insurance, we will gladly process your forms. Our only request is that you pay your estimated portion when services are rendered. Please remember that our contract for payments is with you and your insurance carrier. If you have provided us with your complete insurance information, we will bill your insurance as a courtesy to you.

- Cancellations/Missed Appointments - * by checking you are initialing * - We know that your time is valuable and so is ours so we ask that you provide us a forty-eight (48) hours advanced notice for cancellation of appointments. We reserve the right to collect a \$100 fee for the last minute cancelled appointment or no call no show, this would be non-refundable. If you continue to cancel, reschedule, or miss appointments you will be asked to pay a \$100 appointment deposit. If the appointment is failed this deposit is non-refundable.
- Self Pay Patients - * by checking you are initialing * - We ask that you put \$100 down to hold your appointment with our office and pay the remaining balance day of service. If the appointment is failed this deposit is non-refundable.
- Friday Appointments - *by checking you are initialing* - We ask that all Friday patients put down at least \$50 for an appointment hold. If the appointment is failed an additional \$50 will be charged, totally \$100. The total \$100 being non-refundable.
- Family Policy - *by checking you are initialing* - To schedule 3 or more family members on the same day, we require a \$50 deposit fee for each family member.
- Appointments 70 minutes or more - * by checking you are initialing * To reserve an appointment, we require that you pay 50% or \$100 towards of your estimated patient portion before the appointment to reserve that time. We require two (2) business days' notice for changes to treatment appointments. If you are not able to keep an appointment, as per these guidelines, your reservation fee will be non-refundable.
- Email and Text Messages - * by checking you are initialing * - Due to the changing world of healthcare and technology, Mequon Smile Design has the ability to provide our patients with certain types of information via e-mail and/or text messaging. If you wish to have the opportunity to receive information of this type, please complete the form below. Mequon Smile Design believes strongly in protecting the privacy of our patients. When you provide this information to us, it is only used as a way to communicate with you. Mequon Smile Design does not share the names, email addresses, and/or telephone numbers of patients with any other company, with our patients.
- Consent for Internet Communications - * by checking you are initialing * - I grant my permission to the dental practice to upload and store confidential information (including account information, appointment information, and clinical information) to the secured website for the dental practice. I understand that, for security purposes, the site requires the dental office to use a user ID and password. I also understand the dental practice and I am responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice website with my ID and Password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns. I also understand that State and Federal

Laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make sure of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage, of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload, and use my information in connection with its operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the website on my behalf. I understand the dental practice **CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED, OR RECIEVED USING THE SITE OR THE SERVICES.** I have read the information above regarding the secured uploading of patient information to the website for the dental practice and grant the dental practice permission to securely upload my patient information to the website.

- HIPPA Acknowledgement - *by checking you are initialing*** - I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been take in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I confirm that all information above is understood. Please sign and date to acknowledge.

Signature

Date