Lithonia Pediatric Dentistry - Stonecrest

Registration and Insurance Update

Account # _____
Office Use Only

Patient's Name _____ Age _____ Date of Birth ___/___/_____
LAST FIRST MI

Address _____
STREET CITY STATE ZIP

Home Phone Number _____ Mom's Cell # _____ Dad's Cell # _____

E-Mail Address _____

Father's Name _____ Mother's Name _____

Father Employed By _____ Business Phone _____

Mother Employed By _____ Business Phone _____

Next of Kin Not Living With You _____ Phone # _____

Name of Dental Benefits Plan _____ Policy # _____
Person Financially Responsible/ Guarantor _____

Please List Additional Insurance Coverage if Applicable:

Name of Dental Benefits Plan _____ Policy # _____
Person Financially Responsible/ Guarantor _____

Child's Interest: _____
Child's Favorite Fictional Character: _____

How did you hear about our office?

☐ Office Sign ☐ Direct Mail ☐ Internet ☐ Insurance ☐ Yellow Pages ☐ Dentist _____

☐ Web Site ☐ Returning Patient ☐ Physician _____ ☐ Other _____

It is customary to take care of any fees at the time that services are rendered unless other arrangements have been made. To assist you with this we accept Visa and Master card. Dental insurance is welcome, however it should be understood that you will be responsible for any portion not paid by insurance. Payment will be expected for the services provided.

As a service to our clients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your cell phone number, you consent to receiving such calls at this number.

Comments: _____

Signature: _____ Date _____

Lithonia Pediatric Dentistry - Stonecrest
7215 Stonecrest Parkway
Lithonia, GA 30038
www.mychildssmile.com
Telephone 770-482-4661

WELCOME

We would like to take this opportunity to welcome you to our office. To help us to serve you better, we have prepared this brochure with some important information. We hope to build a lasting relationship with our patients, so please ask us if you have any questions.

APPOINTMENTS

It is our intention to stay on schedule at all times. Occasionally we may experience interruptions in our schedule due to emergencies or other delays. Please be on time for your appointment. Our procedures require the full amount of scheduled time for treatment. If you are late we may require the appointment to be rescheduled. All of our appointments are scheduled specifically for each patient. Therefore we require **24 HOURS NOTICE IF YOU MUST CHANGE OR CANNOT KEEP YOUR APPOINTMENT.** There is a $25 fee for any missed cleaning appointment and a $50 fee for any missed treatment appointment without 24 hours notice. If a missed appointment fee is applied, the fee must be paid before another appointment can be made. This fee is not covered by insurance. All patients must be accompanied by a parent or legal guardian. We require the parent or guardian to remain on the premises for the entire time that treatment is being rendered. All required forms for treatment must be signed by the parent or guardian in person before treatment can be scheduled.

INSURANCE

We welcome dental insurance and we will submit your forms to your insurance carrier as a courtesy to you. It should be understood that you are responsible for full payment of your bill, not your insurance company. Any disputes as to why your insurance carrier did not pay for or cover a certain procedure should be settled by you and your employee benefits office. Your employer can supply you with the appropriate information on your specific dental coverage. We will file your claims in a timely manner, but we cannot be held responsible for any delays caused by your insurance carrier. Any outstanding claims not paid by your insurance carrier after 90 days must be paid by the insured. It is your responsibility to notify us of any changes in your coverage. It is our policy to verify coverage. We recommend the filing of a pre-treatment estimate to determine what your portion will be for each visit. This is only an estimate and not a guarantee of payment by your insurance carrier. We will quote your *estimated* portion that will be due at the time of each visit when you make an appointment. Payment of your estimated portion that is not covered by your insurance is expected at the time that treatment is provided. Again please note that this is only an estimate. Your insurance carrier will make the final determination as to your coverage once the visit is submitted for payment.

YOUR ACCOUNT

Payment is expected at the time that services are rendered. We accept VISA and MASTERCARD cash and personal checks for your convenience. You will receive a printout of your services at each visit. It is our policy that all accounting or insurance related questions and concerns should be directed to and managed by our administrative staff. For treatment provided at an outside outpatient facility, additional or alternative payment policies will apply. As with any other business there is a finance charge for overdue accounts. There will be a $25 charge for any returned check regardless of the reason. We reserve the right to verify funds on all personal checks. Outside collection services will be utilized by our office for all unpaid balances.

THANK YOU

The information stated above is not all inclusive, but it should serve as a guide to our office policies. We welcome new patients and are grateful to our patients who have referred their family and friends to our office. Your expression of confidence is greatly appreciated. We thank you in advance for your cooperation and hope to serve you well in the years to come.

_____ ____________

Signature Date

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractural agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to insurance benefits for payment and pre-treatment authorizations. I hereby authorize payment of benefits directly to this practice.

_____ ____________

Signature Date