WELCOME – TELL US ABOUT YOUR CHILD

Child's Name: ____
Last *First* *Preferred Name*

Address: ______________________________ City: ________________ State: _____ ZIP: _______

DOB: ______________________________ ❒ Male ❒ Female

School: ________________________________ Grade: ________

Father's Name: ____

Address: ______________________________ City: ________________ State: _____ ZIP: _______
Fill in above if different than your child's

Mother's Name: ____

Address: ______________________________ City: ________________ State: _____ ZIP: _______
Fill in above if different than your child's

Home Phone: ______________________________ Work Phone: ______________________________

Cell Phone: ______________________________ E-Mail Address: ______________________________

How did you hear about our office? ____

Do you prefer to be contacted for appointed confirmation via: ❒ Email ❒ Text ❒ Phone (❒ Home ❒ Cell ❒ Work)

Insurance – Primary

Subscriber Name: ____________________ Relationship to Patient: ________ Subscriber DOB: __________

Subscriber SSN/ID: ____________________ Subscriber Employer: ______________________________

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: _______________ Group Number: ______________________________

Insurance – Secondary

Subscriber Name: ______________________ Relationship to Patient: Subscriber DOB:__________________

Subscriber SSN/ID: ______________________ Subscriber Employer: ______________________________

Insurance Company Name: ____

Insurance Company Address: ____

Insurance Company Phone: _______________ Group Number: ______________________________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Postol, D.D.S. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges weather or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: ____

Relationship: ____________________________________Date: ______________________________

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: ____

Kevin F. Postol, DDS
FAMILY AND COSMETIC DENTISTRY

DENTAL AND HEALTH INFORMATION

When was the child's last dental cleaning? ______________________________

Has the child ever had: *(check all that apply)*

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
❒	❒	Cavities	❒	❒	Toothache	❒	❒	Missing Teeth
❒	❒	Mouth Pain	❒	❒	Extracted Teeth			
❒	❒	Gum Infection	❒	❒	Braces *(please list orthodontist)*			

Has the child ever had any complication following dental treatment? *If yes, please explain:*

❒ Yes ❒ No ______________________________

____

Name and Number of Pediatrician: ______________________________

____

Does the child have any health concerns that need further clarification? *If yes, please explain:*

❒ Yes ❒ No ______________________________

____

Does the child have any drug allergies? *If none, please write "none".* ______________________________

____

Please list any medications the child is taking. *If none, please write "none".* ______________________________

____

Has the child ever had any of the following?

Yes	No	Conditions	Yes	No	Conditions	Yes	No	Conditions
❒	❒	AIDS/HIV	❒	❒	Excessive Bleeding	❒	❒	Tonsils are still present
❒	❒	Anemia	❒	❒	GERD/Acid Reflux	❒	❒	Teeth Grinding at Night
❒	❒	ADD/ADHD	❒	❒	Heart Disease	❒	❒	Radiation Treatment
❒	❒	Asthma	❒	❒	Heart Murmur	❒	❒	Rheumatic Fever __________
❒	❒	Diabetes	❒	❒	Hepatitis	❒	❒	Tuberculosis __________
❒	❒	Epilepsy	❒	❒	High Blood Pressure	❒	❒	Transplant/Prostheses

Has the child had any recent surgeries or any health conditions not mentioned above? ______________________________

____

Please list the child's interest and hobbies: ______________________________

FINANCIAL POLICY

At **Kevin F. Postol, D.D.S.,** we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you do have dental benefits, you are very fortunate. Here are some important things you should know:

Initial

_______ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay in full for completion of your dental care. It is only meant to assist you.**

_______ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally hundreds of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have but it is **ONLY AN ESTIMATE.** If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will you a more accurate out of pocket figures you may require.

_______ We will bill your insurance as courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_______ **Kevin F. Postol, D.D.S.** does require payment in full for your portion at the time services are rendered unless prior payment arrangements have been made. We accept MasterCard, Visa, Discover, cash and checks. If you are in need of an extended finance option: we also work with CareCredit who offer 6,12 or 18 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan on approved credit.

_______ 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 24 hour** notice to avoid a **$35/hour cancellation fee** (emergencies are an exception).

_______ In the event of an emergency after regular business hours a **$55 emergency fee** will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged **$125 after hours emergency fee.**

I agree with the above conditions.

Print Name: ______________________________ Date: ______________________

Patient/Parent Signature: ____