# Welcome

We would like to welcome you and your child to our office. Our goal is to make every childís visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime

Todd Kleinrichert, D.D.S. - Margaret Neese, D.D.S. - 210 W. Whitley - Street Churubusco, IN 46723 - 260.693.9300

## 1 Tell Us About Your Child

Today's Date: _____

**Child's Name:** _____
Last First MI

Child's Home Address: _____
Apt/Condo #

_____
City State Zip

Child's Home # _____

Child's Birthdate: _____ Child's Age: _____

Child's SS#: _____

Nickname: _____ ☐ Male ☐ Female

## 2 Who is Accompanying the Child Today?

Name: _____

Relation: _____

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

Is the child adopted? ☐ Yes ☐ No

Is the child in a foster home? ☐ Yes ☐ No

Parent's Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

## 3 Person Responsible for Account

☐ Mother ☐ Step ☐ Guardian

☐ Father ☐ Step ☐ Guardian

Name: _____ Birthdate: _____

Billing Address: _____

_____

Hm Email: _____

Wk Email: _____

Wk #: _____ Ext. _____

Hm #: _____

Employer: _____

SS #: _____ DL #: _____

## 4 Whom May We Thank?

**Please check a referral source below.**

☐ Yellowbook ☐ Yellow Pages ☐ Internet/Website
☐ Sign Out Front ☐ Billboard ☐ 1-800 Dentist

☐ Television (be specific): _____

☐ Radio (be specific): _____

☐ Family/Friend (referral name): _____

☐ Community Event/Fair (be specific): _____

☐ Other (be specific): _____

## 5 Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Insured's Address: _____

### Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Insured's Address: _____

**In the event of an emergency, is there someone who lives near you that we should contact?**

His/Her Name: _____ Relation: _____

Wk #: _____ Hm #: _____

Address: _____

_____

CONTINUED ON BACK

## 6 Medical Information

Child's Physician: _____

Phone #: _____ Date of last visit: _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

_____

_____

Please list all drugs that the child is allergic to:

_____

_____

Does/did the child have any of the following habits?

Y N Lip Sucking/Biting

Y N Nursing Bottle Habits

Y N Nail Biting

Y N Thumb/Finger Sucking

Was the child breast fed? ☐ Yes ☐ No

## 7 Has the child ever had any of the following medical problems?

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Abdominal Bleeding | Y | N | Hearing Impairment |
| Y | N | Allergies to any Drugs | Y | N | Heart Murmur |
| Y | N | Anemia | Y | N | Hemophilia |
| Y | N | Any Hospital Stays | Y | N | Hepatitis |
| Y | N | Any Operations | Y | N | Hives |
| Y | N | Asthma | Y | N | HIV+/AIDS |
| Y | N | Cancer | Y | N | Immunizations Current |
| Y | N | Chicken Pox | Y | N | Kidney/Liver Problems |
| Y | N | Congenital Heart Defect | Y | N | Measles |
| Y | N | Convulsions/Epilepsy | Y | N | Mononucleosis |
| Y | N | Diabetes | Y | N | Rheumatic/Scarlet Fever |
| Y | N | Exposed to HIV, but Neg. | Y | N | Skin Rash |
| Y | N | Handicaps/Disabilities | Y | N | Tuberculosis (TB) |

Anything you would like to discuss with Doctor in private?

☐ Yes ☐ No

Please discuss any serious medical problems that the child has had:

_____

_____

**I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.**

I understand that I am responsible for payment of services rendered and shall be responsible for any collection fees or attorney fees incurred should they be deemed necessary for collection of debt.

_____ _____

Signature of Parent or Guardian Date

**Payment is due in full at the time of treatment.**

We want our patients to be able to comfortably afford dental care.
We will gladly discuss our financial policies with you before beginning your treatment.
We require 24 hours notice to change or cancel an appointment to avoid being charged for the appointment.

Thank you for filling out this form completely. It will enable us to help you more effectively.
If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

# Turtle Town Dental

210 West Whitley Street, Churubusco, IN 46723
P: 260.693.9300 F: 260.693.1376

## INDIVIDUALS INVOLVED IN MY CARE

| PATIENT NAME (LAST, FIRST, MI) | |
|---|---|
| ADDRESS | CITY/STATE/ZIP |
| DATE OF BIRTH | SSN |

I understand that Turtle Town Dental is not always able to provide information regarding my care to others because my health information is protected by law. There are times when that information can be disclosed without my direct authorization if it is relevant to my care, such as: times of emergency, if I am unconscious, or if I have a family member or friend with me when speaking to a health care professional.

However, at times it may be difficult for Turtle Town Dental to identify whether someone is a family member, friend, or other individual who is involved in my care, and I may not always be able to provide that information, such as if there is an emergency, if I cannot communicate, or for other reasons. To assist my healthcare providers in making these decisions, I am disclosing below any individuals involved in my care that can be contacted about or provided with information about my medical status, whereabouts, treatment instructions, medications, or other matters relevant to my care of medical status. I understand that I am giving Turtle Town Dental permission to disclose my protected health information to these individuals if and when Turtle Town Dental feels it is appropriate.

NAME: _____ Relationship: _____ PH # _____

NAME: _____ Relationship: _____ PH # _____

NAME: _____ Relationship: _____ PH # _____

This authorization is in effect until revoked by me. I have the right to revoke this authorization in writing at any time. I am signing this authorization voluntarily. No treatment, payment, or eligibility for benefits will be affected if I do not sign this authorization.

Please initial the 2 lines below & sign & date on the bottom line

_____ **I AGREE TO THE ABOVE AND UNDERSTAND THIS WILL REMAIN IN EFFECT UNTIL I NOTIFY Turtle Town Dental OF ANY CHANGES IN WRITING.**

_____ **I have received a copy of this office's Notice of Privacy Practice, or read the copy in the office.**

_____ _____

Signature of Patient (or legal guardian) Date

**OVER →**

## FINANCIAL POLICY AND RELEASE BENEFITS

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Feel free to ask about our fees, Financial Policy, or your responsibility.

## If YOU HAVE INSURANCE

Dental insurance is a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage, and to provide our staff with accurate information to process your claim efficiently (i.e. insurance company address, phone number, etc.). It is not our place to enter into disputes between you and your insurance company regarding deductibles, copayments, etc. other than to provide factual information. We do not directly participate with most insurance programs; however, as a courtesy, we do process your claim for payment to be made directly to you. Certain conditions may apply to your financial arrangements that may require your authorization for release and assignment of benefits. Your signature below authorizes us to offer this when it applies to your situation. If we do not participate with your insurance, 100% of the total cost is requested at the time of treatment. If you are unable to pay 100%, affordable payment options are available. Our staff will help you process whatever paperwork is required. However, the ultimate responsibility lies with you for payment of any and all monies due.

## YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT

## RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Turtle Town Dental to release to my benefit program or its representative any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize, if applicable, payment to be sent to Turtle Town Dental.

## I AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED

_____ _____

Signature of Patient (or legal guardian) Date

# CHANGE OF APPOINTMENT POLICY

Thank you for choosing Turtle Town Dental. We look forward to caring for you and your family. We believe that every patient deserves to have a smile they can be proud of for a lifetime.

At Turtle Town Dental, we strive to deliver quality, patient centered care with a whole-body approach while providing the finest products and services the industry has to offer.

In an effort to continually meet this standard of care we adhere to a **Change of Appointment Policy**. This policy allows other patients the chance to be scheduled into a previously occupied appointment.

**Policy & Fees:**

- Patient must provide at least 48 hours of advanced notice prior to rescheduling or cancellation.
- Failure to give 48 hours' notice will result in a $100 cancellation fee.
- This fee cannot be billed to your insurance provider and will be your direct responsibility.

We understand that illnesses, emergencies, flat tires, bad weather, and sometimes life just happens. Our team will always do our best to accommodate your needs.

We appreciate your understanding and consideration regarding our Change of Appointment Policy. Should you have any questions or concerns, please don't hesitate to speak with a Turtle Town Dental team member.

Thank you for your continued loyalty and support. We look forward to seeing you and your family soon.

Thank you,
Your Turtle Town Dental Team

*I have read and understand the Change of Appointment Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.*

*Signature* _____ *Date* _____