JUST FOR GRINS
family dentistry

Patient's Name:_____
Last First Middle Preference

Birth date:_____ Male / Female:_____ Social Security# _____

Address: _____
Street Apt. # City State Zip

Best Contact Number: _____ Family Email Address: _____

Patient lives with: _____ How did you hear about us? : _____

Is a member of your family a patient here:_____ Name:_____

Primary Guardian/Parent

Name: _____ Date of Birth: _____ Driver's License# :_____

Relationship to Patient: _____ Phone#: _____

Address _____

Employer: _____ Social Security # _____

Secondary Guardian/Parent

Name: _____ Date of Birth: _____ Driver's License# :_____

Relationship to Patient: _____ Phone#: _____

Address _____

Employer: _____ Social Security # _____

Emergency Contact Information: (Not living with patient)

Name: _____ Relationship to child: _____

Phone#: _____ Address _____

Insurance Information:

Name of insured: _____ Relationship to Patient: _____

Birthdate: _____ Social Security #: _____ Employer: _____

Insurance Co: _____ Group #: _____ Phone: _____

I hereby authorize Just For Grins to affix my name to insurance claims and payments .I authorize payment of dental benefits, otherwise payable to me, directly to Just For Grins.

Patient/Guardian Signature:_____ Date:_____

Kids Medical History

Patient Name:_____ Is your child currently taking any medications? Yes/No

Medication List: _____

Are there any specific questions or concerns that you would like to have addressed today? Yes/No

List: _____

When was your child's last dental visit?_____ Previous Dentist _____

Has your child experienced any unfavorable reactions from previous dental or medical care? _____

How often does your child brush?_____ Floss? _____ Is it supervised? Yes/No

Has your child had orthodontic treatment? Yes/No Phase 1 Phase 2 Orthodontist _____

Please check any of the following that apply to your child:

	Condition
	ADD/ADHD
	AIDS/HIV
	Allergies
	Anxiety
	Anemia
	Artificial Heart Valve
	Artificial Joints
	Asthma
	Autism- Mild Severe
	Behavioral Problems
	Birth Defects
	Blood Disease
	Blood Pressure: High or Low (circle)
	Brain Injury
	Bruise Easily
	Cancer type:
	Chemical Dependency
	Chemotherapy
	Chicken Pox
	Child Abuse
	Cleft Palate/Lip
	Cold Sore/Canker Sore
	Developmentally Delayed: Age level is
	Depression
	Diabetes
	Dizziness/Fainting
	Down Syndrome
	Earaches/Infection
	Eye Conditions
	Excessive Bleeding

	Condition
	Hearing Impairment
	Heart Condition
	Heart Murmur
	Hemophilia
	Hepatitis A B C
	Hospital Stay/Operation:
	Injury to Front Teeth
	Kidney Disease
	Liver Disease
	Lupus
	Mentally Handicapped
	Metallic Implant, Shunts, Pins, Rods
	Mitral Valve Prolapse
	Mononucleosis
	Pacemaker
	Psychiatric Care
	Radiation Head Neck Other:
	Recreational Drugs
	Rheumatic Fever
	Rheumatism
	Scarlet Fever
	Seizures type:
	Sleep Apnea or Snoring
	Sore Throats
	Speech Impairment
	Stomach Problems
	Stroke
	Thyroid Disease
	Tuberculosis
	None

	Allergic to:
	Aspirin
	Codeine
	Erythromycin
	Latex
	Local Anesthetic
	Nitrous Oxide
	Penicillin
	Food
	Other

	Does your child receive
	Bottled Water
	Fluoridated Water
	Fluoride (supplements)
	Well Water

	History of
	Breastfeeding
	Thumb sucking
	Pacifier
	Nighttime Bottle/ Sippy Cup
	Teeth Grinding
	Clicking of Jaw

If you answered yes to any of these questions, please explain: _____

Is there any other medical or dental information we should know? _____

Is your child under a physician's care? Y/N Reason? _____

Physician:_____ Phone Number:_____

Patient/Guardian Signature:_____ Date:_____

Team member:

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Consent for Purposes of Treatment, Payment and Healthcare Operations

Patient Name: _____ Date of Birth: _____

I understand that Just For Grins may use and disclose my protected health information for the purpose of treatment, payment of bills or in the performance of health care operations of Just For Grins. I may obtain a copy of the Notice of Privacy Practice at any time upon request. The Notice provides a description of the uses and disclosures Just For Grins may make of my protected health information. Protected health information refers to any health information, such as the information collected from me and created or received by my doctor, another health care provider, a health plan, employer or a heath care clearinghouse. This information relates to my past, present or future health or condition and there is reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment, obtaining payment for my health care services or to conduction health care operations. Heath care operations may include email reminders, phone calls, texts and correspondence asking for feedback or inviting me to share my experiences via surveys and/or social media. I have the right to revoke this consent, in writing, at any time. If I choose to revoke this consent, I understand that the doctor or practice may have already released information based on my original consent.

I understand that if I would like to authorize the release of protected health information to any person other than myself (parents, spouse, children, etc) they must be listed below. This information may include: diagnosis, records, examination, treatment rendered, ledger, billing and claims information. My protected healthcare information may be released to:

_____

_____

As a service to our patients, we may provide courtesy appointment reminders or other calls, emails and/or texts. By providing us with this information, you consent to receiving such calls/emails/texts.

_____ _____
Signature of Patient or Personal Representative Date

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____ Relationship to Patient: _____

We understand that there may be times it is not possible for the parent or legal guardian of a child to bring him/her to their dental appointment. You may give permission for others to bring your child by filling out the following. If you leave this section blank, only a parent or legal guardian will be allowed to consent to treatment or schedule an appointment.

I, _____, parent/guardian of

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

give permission to

Name: _____ Relationship to Patient : _____

Name: _____ Relationship to Patient : _____

Name: _____ Relationship to Patient : _____

Name: _____ Relationship to Patient : _____

to consent to dental treatment for my child/children. I will make sure the above individual(s) are aware of the medical history of my child and will be able to answer any questions required for treatment. I understand and agree that the treatment plan that may have been presented to me is subject to change. In some cases, this may change the expected copayment. I will make arrangements for the above individual(s) to bring any necessary insurance information and payment for services at each appointment.

Patient/Guardian Signature: _____ Date: _____

Financial Agreement

Patient Name _____

- It is your responsibility to provide us with your most current insurance information. If you change insurance or fail to maintain insurance, you must notify our office immediately.
- If you fail to provide accurate insurance information to us in a timely manner (prior to your insurance termination), your insurance company may deny your claim. If the claim is denied, you will be financially responsible for services rendered.
- Please note, as dental providers, our relationship is with you, not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand your benefits and eligibility.
- We may accept assignment of insurance after verification of your coverage. Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. Therefore, you are financially responsible for services not covered by your insurance company. It is your responsibility to know your benefits.
- Prior to receiving services, you must verify that we are participating providers for your insurance company by calling your insurance company or logging in to your carrier's website.
- We charge usual and customary fees. You are responsible for payment if your insurance company disputes payment for your claim.
- Copayments, coinsurance and/or deductibles are due at the time of service. We will provide a good-faith estimate of the amount you owe based on information we receive from your insurance company. This will only be an estimate and in no way does it imply a contractual arrangement indicating and agreed upon amount actually due. We will not know how much is actually due by you until we receive payment from your insurance company. You are responsible for paying the full amount determined by your insurance company once they have paid your claim- regardless of our estimation. Please review your explanation of benefits or contact your insurance company if you have any questions.
- **Full payment is due at the time of service**. We accept cash, checks, credit cards and Care Credit.
- If you are not able to pay the balance due in full, you must contact our billing office directly to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.
- We will send a statement to the billing address on file to notify you of any balances you may owe. If you have any questions regarding your balance, it is your responsibility to contact our business office after receipt of the initial statement. Please call our billing office directly at 817.741.4455. We will assume you do not dispute the charges if you do not contact our office within 30 days of receipt of a statement.
- **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to a monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity**.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable. The laws of the state of Texas apply and venue is proper in Tarrant County.
- If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer be able to receive services from Just For Grins.
- All returned checks are subject to a $25.00 charge in addition to your original balance.
- You must provide your most current billing address, telephone numbers and any other important contact information. If your address or contact information changes, please fill out our information update form in the office, or call us with the new information.
- If you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date, you may be subject to a "broken appointment" fee of $50.00
- **Divorced Parents** It is the policy of this office that the parent/guardian accompanying the child to the visit be held responsible for treatment consents and all charges incurred; regardless of insurance, divorce decrees, or financial situations. We do not bill third parties and do not accept assignment of benefits from secondary insurance

Patient/Guardian Signature _____

The "claim" is based on the services provided for any given date of service. There may be more than one "claim" as well as more than one "date of service" or "service" provided. This Agreement contemplates all claims for all services rendered on any given day

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Cancellation Policy

To make sure every patient gets individual attention, we reserve a dedicated time for each appointment. We recognize that adhering to a schedule is important in order to maximize time and meet the demands of daily life. With this in mind, we have developed a cancellation and late arrival policy that is fair to both our patients and our practice.

We are committed to seeing our patients on time and request that you arrive to your appointment at the scheduled time. We reserve time just for you! If you must be late, we will do our best to see you but may not be able to complete all the scheduled procedures. You may be required to schedule a separate appointment to finish those procedures. If you are going to be more than 15 minutes late, you may be asked to reschedule your appointment.

We request 24-hour notice if you need to cancel your appointment. We appreciate your cooperation and understanding.

Patient Name: _____ Date: _____

Signature: _____