

Welcome!

Natalie A. Lenser, D.D.S

3109 Coffee Road, Suite B, Modesto, CA 95355, 209/571-7283, Fax / 571-7285

Patient ID # _____

Policy Holder ID # _____

Responsible Party # _____

Name of Minor/Child _____
Last Name _____ First Name _____ Middle Initial _____

Sex: Male _____ Female _____ Birthday _____ Nickname _____ Hobbies _____

Childs Home Address _____
Street _____ City _____ State _____ Zip _____

Mailing Address _____
(if different) Street _____ City _____ State _____ Zip _____

Who is accompanying the child today? Name _____ Relationship _____

Phone Home: _____ Cell: _____ Mom or Dad _____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Email Address: _____

In the event of an emergency, whom should we contact? Someone other than Parent/Legal Guardian.

Name: _____ Relationship _____ Phone _____

Whom may we thank for referring you? _____

Father's/Guardian's Name _____

Address _____

Phone: Home _____ Work# _____
(If different from above)

Soc. Sec.# _____ Birthdate _____

Employer _____

Do you carry dental insurance coverage for your child? Yes No

Insurance _____

Phone No. _____

Address _____

Group # (Plan, Local or Policy) _____

Mother's/Guardian's Name _____

Address _____

Phone: Home _____ Work # _____
(If different from above)

Soc. Sec.# _____ Birthdate _____

Employer _____

Do you carry dental insurance coverage for your child? Yes No

Insurance _____

Phone No. _____

Address _____

Group # (Plan, Local or Policy) _____

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT: I request and authorize treatment of the person named above and agree, irrevocably, whether signing as agent or as patient, that in consideration of the services to be rendered to the patient that I hereby individually obligate myself to pay the account in accordance with the regular rates and terms of the provider. I hereby give authorization for payment of the insurance benefits directly to provider named above, and any assisting physicians for services rendered. As required by law, you are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay actual attorney's fees and collection expenses. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original). Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **A \$25.00 fee is charged on all returned checks. A \$25.00 service charge will be assessed on all accounts not settled within each 30-day cycle after determination of patient responsibility. In addition to cash or check, Visa, MasterCard, American Express and Care Credit are accepted.** **RELEASE OF INFORMATION:** The provider may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the provider or to the patient, family member, or the employer of the patient or the family member for all or part of the providers charge, including but not limited to, medical service companies, workman's compensation carriers, welfare funds, or the patient's employer. I further authorize my employer to release employment information to the provider or the provider's agents.

Signature

Date

OVER →

Dental History

Date of last dental visit _____

Previous Dentist _____

Child's physician _____

Physician phone # _____

Pharmacy _____

Circle Correct Answer for all Questions below

Snoring when sleeping	Yes	No
Does your child have sleep apnea	Yes	No
Bleed excessively when cut	Yes	No
Latex Allergy	Yes	No
Metal Allergy	Yes	No

Medical History

Reason for today's visit _____

Is your child under the care of a physician now? Yes No Reason _____

Is your child taking Medication daily? *If yes please list.* Yes No _____

Does your child have any Drug Allergies? *Please List* Yes No _____

Does your child take liquid medication well? Yes No _____

Has your child ever been hospitalized? For what? Yes No _____

Has your child ever had surgery? When/What Yes No _____

Does your Child have special needs? *If yes please list:* Yes No _____

Does your child have any medical problems/ conditions? Yes No _____

Please Explain _____

Has your child ever had any of the following? **Please Circle All**

Yes No A.I.D.S/H.I.V	Yes No Diabetes	Yes No Kidney Disease	Yes No Seasonal Allergies
Yes No ADHD/ADD	Yes No Autism	Yes No Measles/Mumps	Yes No Lung Problems
Yes No Anemia	Yes No Epilepsy/Seizures	Yes No Liver Disease	Yes No Tonsillitis
Yes No Asthma	Yes No Drug/Alcohol Abuse	Yes No Mononucleosis	
Yes No Bladder Problems	Yes No Fainting	Yes No Rheumatic/Scarlet Fever	
Yes No Bleeding Disorder/Disease	Yes No Hearing Problems	Yes No Rash/Hives	
Yes No Cancer	Yes No Pain in Jaw Joints	Yes No Sinus Problems	
Yes No Cerebral Palsy	Yes No Heart Problems/Murmur	Yes No Thyroid Disease	
Yes No Chicken Pox	Yes No Congenital Heart Defect	Yes No Frequent Headache	
Yes No Cold Sores/Fever Blisters	Yes No Convulsions	Yes No Tuberculosis	
Yes No Hemophilia	Yes No Hepatitis	Yes No Premature Birth	

Dentist Comments _____

Dr. Initials _____

Authorization for Release

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payer and/or health practitioners.

Parent/Legal Guardian

Date

For office use only

Pt Wt _____ lbs

RDA _____

P: UR LR UL LL RD

DL Ck _____

Natalie A. Lenser, D.D.S

DIPLOMATES OF THE AMERICAN BOARD OF PEDIATRIC DENTISTRY
3109 Coffee Road, Suite B
Modesto, CA 95355
(209)571-7283 Fax (209)571-7285

FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards (VISA, Mastercard, American Express and Care Credit). We will bill your insurance company as a courtesy to you. If you have Dental Insurance and your insurance company pays you directly, you will be considered a cash paying patient.
2. As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for reimbursement or you may assign the payment to our office and we will file the primary insurance for you. Secondary insurance will be filed only if the correct information is provided at the time of service.
3. You must provide the office with the correct dental insurance information at the time of the service. This will include the Subscribers social security number, date of birth along with the name of the dental insurance, mailing address, phone and group number. If insurance coverage cannot be verified you will be responsible for payment of all fees. We will provide you with all necessary information to submit to your insurance company for reimbursement.
4. Dental benefit plans may cover only part of your dental treatment. It is understood that you are responsible for the entire balance of your account. The contract of dental benefits is between the patient and the insurance company. The fact that we do not write or administer your Dental Benefit plan makes it impossible for us to assure any payment from a third party carrier for any parts of the above estimated treatment plan. You are responsible for all services rendered, regardless if you have dental benefits or not. We will bill your insurance as a courtesy to you.
5. Our office will make every reasonable effort to obtain payment from your insurance company. If the claim remains unpaid after 90 days, you will be responsible for the remaining balance. Your account will be assessed and additional \$25.00 fee if collection services are required
6. A fee of \$50.00 will be charged for all failed appointments and appointments cancelled with less than 48 hours notice. There will be a \$25.00 charge for all returned checks.
7. The parent or guardian who brings the child for an initial visit is the responsible party. This parent is required to pay for services rendered regardless of what a divorce decree may state.

AUTHORIZATION

1. I hereby give authorization for payment of insurance benefits directly to Natalie A. Lenser DDS for services rendered.
2. I have read and accept the above Financial Policy, understand it, and agree to the terms set forth regarding payment for any and all dental services rendered.

Patient Name

Date

Signature of Parent or Guardian

Print Name