



PEDIATRIC DENTAL CLINIC
DAVID H. MERRITT, D.M.D., M.S., P.C.
PEDIATRIC DENTISTRY
162 ANA DRIVE
FLORENCE, ALABAMA 35630
TELEPHONE (256) 766-0270

I. General Information:

Date _____

Father _____ Date of Birth _____ Social Security # _____

Home Address _____

City, State, Zip Code _____

Home Phone Number _____ Work Phone Number _____ Cell _____

Employed by _____

Address _____ City _____ State _____ Zip _____

Do you have Dental Insurance? Yes ___ or No ___

If yes, Name of Company _____

Group Number _____ Policy Number _____

Family Dentist _____

Email Address _____

Mother _____ Date of Birth _____ Social Security # _____

Home Address _____

City, State, Zip Code _____

Home Phone Number _____ Work Phone Number _____ Cell _____

Employed by _____

Address _____ City _____ State _____ Zip _____

Do you have Dental Insurance? Yes ___ or No ___

If yes, Name of Company _____

Group Number _____ Policy Number _____

Family Dentist _____

Email Address _____

II CHILD'S HISTORY:

Child's Name _____ Nickname _____

Age _____ Date of Birth _____ Place of Birth _____

Male _____ Female _____ Social Security Number _____

Attends What School _____

Names and ages of brothers and sisters _____

Child's Physician or Pediatrician _____ Phone Number _____

Whom may we thank for referring you? _____

Nearest relative not living in the same household _____

Address _____ Phone _____

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PAYMENT POLICY

PATIENT NAME(S): _____

PERSON RESPONSIBLE FOR PAYMENT: _____

S.S.#: _____ RELATION TO PATIENT: _____

ADDRESS: _____

Telephone: Home _____ Office _____ Cell _____

● FOR OUR PATIENTS WITHOUT DENTAL INSURANCE:

- PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
- VISA AND MASTERCARD ARE ACCEPTED.

● FOR OUR PATIENTS WITH DENTAL INSURANCE:

- CO-PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
- WE WILL FILE AN INITIAL CLAIM FOR THE DENTAL PROCEDURE.
- THE AMOUNT OF PAYMENT WILL BE HELD CURRENT FOR 60 DAYS IF AFTER 60 DAYS THE CLAIM HAS NOT BEEN PAID BY THE INSURANCE COMPANY, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

I HAVE READ THE ABOVE PAYMENT POLICY FOR THE PEDIATRIC DENTAL CLINIC AND AGREE TO SUBSCRIBE TO THE APPROPRIATE PAYMENT POLICY PROCEDURE.

Signature of Responsible Party: _____

Date: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my child's protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my child's protected health information to carry out:

- * Treatment (including direct or indirect treatment by other healthcare providers involved in my child's treatment);
- * Obtaining payment from third party payers (e.g. my insurance company);
- * The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my child's protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my child's protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

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