

Winning Smiles Financial Policy

*Our office is committed to providing you with the highest quality dental care using only the best materials and technology available. Our clinical and business teams work closely together to provide a positive environment for visits to our office and assistance with financial requirements. **Payment for professional services is expected at the time dental treatment is provided.** A member of our Business Team will be delighted to discuss our options with you!*

We are happy to file dental claims for our families who have dental insurance. In general, we will file claims to any company that will pay us directly and does not restrict coverage to a list of participating providers. Filing to your insurance carrier is not a guarantee of payment. Please understand that the patient or parent/guardian has the final responsibility for payment of any services rendered. Our doctors recommend treatment based on our patients' needs, not on what insurance will pay.

a. Payment options: For your convenience, we accept cash, personal checks, debit cards, Visa, MasterCard, Discover, Flexible Spending Accounts, Health Saving Accounts and CareCredit.

b. Financial responsibility: Self-pay patients are expected to pay for services received in full at the time of service. Any alternative financial arrangements must be made before you see the dentist. The parent or guardian bringing the child to our office and authorizing treatment is legally responsible for payment of all charges. We cannot send statements to other persons.

c. Divorce/separation: The party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce/separation, the parent or guardian bringing the child and authorizing treatment will be the person responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We will provide you additional copies of receipts if needed.

d. Required payments: At treatment

visits, we collect a percentage of the total cost of treatment, determined by ESTIMATION of what your insurance will cover, plus any deductible required by your insurance. In the event of underpayment, we will send you a statement in the mail. In the event of overpayment on your part, you will receive a credit on your account, or you may request reimbursement by mailed check.

e. Authorization: If your insurance plan requires an authorization we will need to receive the authorization before you or your child sees the dentist. If we have not received the authorization prior to your appointment, we will need to reschedule the appointment until it is received.

f. Deposit: Certain procedures may require a deposit, including deductibles, co-payments and coinsurance. Payment of these amounts is required before the procedure is performed.

g. Uncovered services: In the event your insurance company determines a service to be "not covered," or reimburses Winning Smiles lower than the anticipated amount, you will be responsible for payment. We try to inform patients when services may not be covered; however, it

is the patient's responsibility to understand their dental insurance limitations. Most benefits will be verified before your insurance company can be billed. In the event that your insurance has not paid within 60 days, the balance may be transferred to your account.

h. Returned check fee: A \$35.00 service charge will be applied to your account for any returned check. If a check is returned, we will only accept cash or a credit card as payment on your account.

i. Canceling/rescheduling: Scheduled appointments that are missed, changed, or canceled with less than 48 hours of notice will be charged a fee of \$50 (hygiene appointments) or \$75 (treatment appointments).

j. Past due accounts: Unless prior arrangements have been approved in writing by our office, the balance on your statement is due and payable when the statement is issued. If your account becomes past due over 90 days, a collections process may be used to collect funds. All reasonable expenses incurred during the collection process will be the account holder's responsibility.

Effective date: Once you have signed this policy, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

I have read the above policies and understand my obligations with Winning Smiles for my or my child's dental care. I acknowledge that I am responsible for payment of any services not covered by my insurance plan.

Print name of person signing _____

Relation to patient: _____

Signature: _____

Date: _____

Child and Family History

Patient Information

Patient's Name _____ Nickname _____ Date _____
 Date of Birth _____ Sex _____
 Is Patient Adopted? Yes _____ No _____ If yes, Legal Guardian Name _____
 Name of School _____ Grade Level _____
 Name and Ages of Siblings _____
 Are Any of These Children Currently Patients in This Office? _____
 Child's Address _____
 City _____ State _____ Zip _____
 Home Phone # (____) _____
 Favorite Pet or Toy _____ Pet's Name _____
 Who May We Thank for Referring You? _____
 Yellow Pages _____ Website _____ Newspaper _____ Insurance Company _____ Other _____

Responsible Party Information

Father's Name _____ Date of Birth _____ Marital Status _____
 Social Security # _____ Email Address _____
 Address _____
 City _____ State _____ Zipcode _____
 Home Phone # _____ Work # _____ Cell # _____
 Place of Employment _____ Occupation _____

Mother's Name _____ Date of Birth _____ Marital Status _____
 Social Security # _____ Email Address _____
 Address _____
 City _____ State _____ Zipcode _____
 Home Phone # _____ Work # _____ Cell # _____
 Place of Employment _____ Occupation _____

Dental Insurance Information

Primary Insurance

Name of Insured _____
 Insured's Date of Birth _____ ID # _____ Group # _____
 Insured's Employer Name _____ Address _____
 Insurance Plan Name _____
 Insurance Address _____ Phone # _____

Secondary Insurance

Name of Insured _____
 Insured's Date of Birth _____ ID # _____ Group # _____
 Insured's Employer Name _____ Address _____
 Insurance Plan Name _____
 Insurance Address _____ Phone # _____

Child Health Questionnaire

In order to provide a complete dental exam for your child, please answer all of the following questions as completely as possible.

Date ____/____/____ Child's Name _____
 Birth Date ____/____/____ Age _____ Sex _____

Child's Physician _____

Address _____ Physician Phone Number _____

Date of last physical examination _____

How is your child's general health? _____

Has your child had any serious illness? Yes ___ No ___

If yes, please describe _____

Has your child ever been hospitalized? Yes ___ No ___ **If yes when and for what reason?** _____

Is your child receiving any medication, vitamins, and/or natural remedies at this time? Yes ___ No ___

If yes, please describe _____

Has your child ever had an allergic reaction to the following?

Dental Anesthetics ___ Antibiotics ___ Food ___ Drugs ___ Latex ___ Other ___

If yes, please describe _____

Has your child ever received a blow or injury to his/her head or teeth? Yes ___ No ___

If yes, please describe _____

Has your child ever been treated with X-ray or radiation therapy? Yes ___ No ___

Has your child ever had any of the following conditions? **Please Check:**

	Yes	No	Age		Yes	No	Age		Yes	No	Age
ADD/ADHD				Diabetes				Mentally Challenged			
AIDS/HIV				Hearing Problems				Physically Challenged			
Asthma				Heart Murmur				Pregnancy			
Autism				Heart Problems				Scarlet Fever			
Behavioral Disturbance				Hepatitis				Seizures			
Blood/Bleeding Disorders				Kidney Problems				Stomach Problems			
Cancer				Learning Disability				Tuberculosis			
Cerebral Palsy				Lung Disease							
Other											

If yes to any of the above, please describe _____

Does your child have any habits we should be aware of, such as?

Poor eating habits ___ Thumb Sucking ___ Pacifier ___ Bottles ___ Other _____

Does your child receive fluoride in: Drinking water at home Yes ___ No ___ By prescription Yes ___ No ___

Has your child had any unpleasant dental experiences? Yes ___ No ___

If yes, when? _____

How can we help? _____

Date of last dental examination ____/____/____

Has your child ever had orthodontic treatment? Yes ___ No ___

What is the nature of today's visit? Regular Exam ___ Emergency ___ State Problem _____

Signature of Parent or Guardian _____

Signature of Doctor/Staff _____

Welcome to our practice, and thank you for letting us care for your child's smile!

WELCOME TO OUR PRACTICE!

Dear Parent,

We would like to thank you for selecting us to provide your child's dental care. We hope that this will be the start of a lifetime of optimal oral health for your child!

We have enclosed some information and a brief questionnaire. Please take a few minutes before you come to the office to fill it out completely and bring it with you to your appointment.

If you have dental insurance, please bring a completed form, your insurance card and if available, your insurance booklet. This will help us explain your plan if you have any questions.

Our office places a strong emphasis on preventive care. The first visit is designed to examine, clean, place fluoride on the teeth and begin to teach you and your child about proper oral hygiene and diet. In the long run, it is much easier to prevent dental disease than treat it once it occurs.

We hope this first visit is enjoyable for you and your child! We look forward to seeing you on _____ at _____ at our _____ location. If you have any questions or concerns before your child's first appointment, please feel free to contact us at 716-332-2444.

Sincerely,

A handwritten signature in cursive script, appearing to read "Mike", followed by the initials "DDS" in a smaller, more formal font.

Dr. Mike and the Winning Smiles Pediatric Dental Team