Today's Date: _____

Responsible Party (Parent) Information

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Soc. Sec #: _____ Cell Phone #: (_____)_____-_____

Email Address: _____

Primary Dental Insurance Information

Insurance Company: _____ Group #: _____ ID#: _____

Employer Name: _____ Policy Holder's Name: _____

DOB: _____ SS#: _____

Secondary Dental Insurance Information

Insurance Company: _____ Group #: _____ ID#: _____

Employer Name: _____ Policy Holder's Name: _____

DOB: _____ SS#: _____

Immediate Family Information

Spouse Name: _____ DOB: _____ Phone #: _____

Insurance (if different from above):

Insurance Company: _____ Group #: _____ ID#: _____

Employer Name: _____ Policy Holder's Name: _____

DOB: _____

- Dependent : _____ DOB: _____

Insurance (if different from above):

Insurance Company: _____ Group #: _____ ID#: _____

Employer Name: _____ Policy Holder's Name: _____

DOB: _____

- Dependent : _____ DOB: _____

Insurance (if different from above):

Insurance Company: _____ Group #: _____ ID #: _____

Employer Name: _____ Policy Holder's Name: _____

DOB: _____

- Dependent: _____ DOB: _____

Insurance (if different from above):

Insurance Company: _____ Group #: _____ ID #: _____

Employer Name: _____ Policy Holder's Name: _____

DOB: _____

- Dependent:_____ DOB: _____

Insurance (if different from above):

Insurance Company: _____ Group #: _____ ID #: _____

Employer Name: _____ Policy Holder's Name: _____

DOB: _____

Whom may we thank for referring you:_____

In case of emergency, we may contact: Name:_____

Phone:_____

I give permission for Morning Star Dental to share information regarding my appointments, treatment, and account with:_____

FAILED APPOINTMENTS

One of our greatest obstacles to providing outstanding service is those rare occasions when patients do not show up for their scheduled appointments or show up late. This puts us in a difficult position because we reserve the appointment for individualized care and it is virtually impossible to fill the time. To help prevent broken appointments and provide better service to those patients that do show up, we have implemented the following policy:

1. *An appointment must be canceled with at least 24 hours notice.*
2. *A fee of $50.00 will be charged for a no show or any appointment with out 24 hours notice.*
3. *You may have to be rescheduled if you are 10 or more minutes late.*

We have a short call list we use to try and fill appointments. The key is a simple phone call far enough in advance to allow us to fill the time. We greatly appreciate your assistance in this matter.

_____ Initial

TEXTING AND EMAIL CONFIRMATIONS:

I give Morning Star Dental permission to contact me via text or email regarding appointments.

_____Initial

Morning Star DENTAL

_____ / / _____

Patient Name **Date**

Welcome and thank you for choosing Morning Star Dental. The following is our office policy regarding payments for dental services rendered.

FIRST VISIT: The first visit is expected to be paid in full by all new patients. Payments for office visits are due at the conclusion of each visit. All new patients without insurance will be asked to pay for each visit in full. If necessary, credit arrangements may be considered *after* the first visit. For any unpaid portions, we require a written financial agreement.

INSURANCE: As a courtesy to you, we will review your insurance coverage, estimate your insurance company payment, and file claim(s) with all insurance companies. Your estimated percentage of the total fees and unmet deductibles are due at each visit. If your insurance denies the claim through no fault of the provider/billing department and after all efforts have been exhausted, then you will be responsible for any portion of your bill which is denied or not paid by your insurance carrier. Your insurance coverage is a contract between you and your insurance carrier(s), however, we will assist you to maximize your insurance benefits.

CARE CREDIT: If you are unable to pay in full or do not have insurance and would like extended credit, we do have a plan called Care Credit. If you qualify, they pay us directly and you make monthly payments to them. They will give you a credit limit and you can use it wherever Care Credit is accepted. Depending on the amount that is financed, there is no interest if the amount is paid in full within a certain amount of days. Ask our receptionist if you would like more information about Care Credit.

MEDICAID: We are currently accepting Medicaid for children. We will submit to Medicaid on your behalf for covered services. For any services not covered, it will need to be paid in full before the work can be completed (e.g. dentures, crowns, root canals). You can prepay on your account and when the service is covered, we will perform the procedure.

YOUR INSURANCE IS NOT A SUBSTITUE FOR PAYMENT.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER PAID BY INSURANCE OR NOT.

Please indicate method of payment by checking one of the following:

- Payment is expected when services are rendered. Any other arrangements must be made in writing in advance. See the receptionist with any questions.

I AGREE TO PAY FOR EACH VISIT AT THE TIME OF SERVICE BY:

CASH ( ) PERSONAL CHECK ( ) CREDIT CARD ( ) CARE CREDIT ( )

I acknowledge the above policy and agree to comply.

_____ / / _____

Responsible Party Signature **Date**