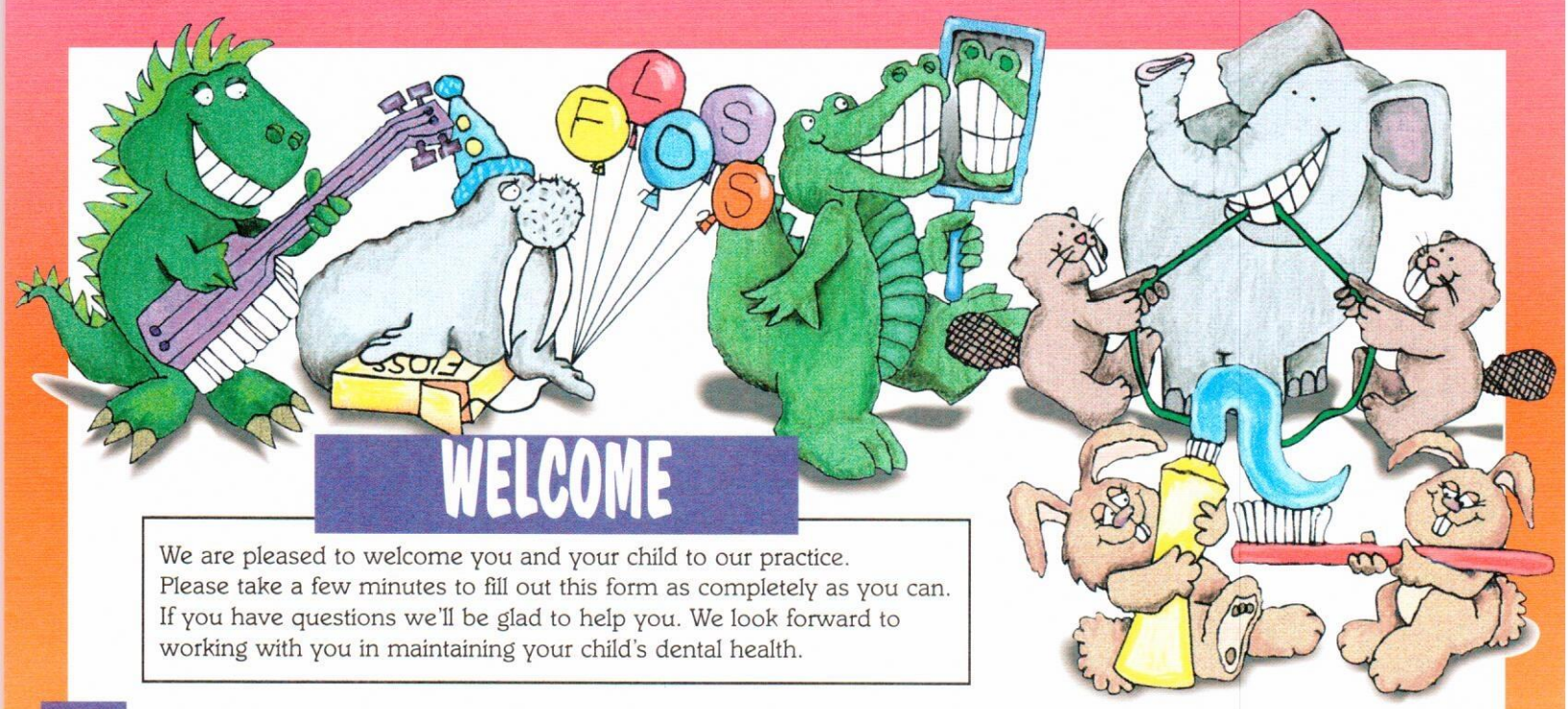


WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home (____) _____ Work (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home (____) _____ (if different from above) Work (____) _____ (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home (____) _____ (if different from above) Work (____) _____ (if different from above)

E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐

	YES	NO
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐

Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ ☐

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

Allergies _____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATION

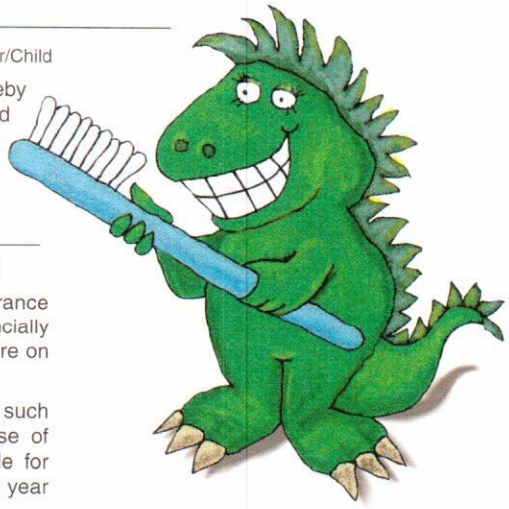
To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.



Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

Family Dental Care, LLC
Dr. Erica Fisher, Dr. Kristy Fisher, and Dr. Amy Bagley
6300 N Revere, Suite 210
Kansas City, MO 64151
(816)505-9767

GENERAL CONSENT AND INFORMATION FORM

It is the belief of this office that you should be informed about the treatment (therapy) we may recommend, and that you should give your consent before starting that treatment. The purpose of this form is to advise of the risks that may occur in dental treatment and other treatment choices.

RISK OF DENTAL PROCEDURES IN GENERAL: Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (painkillers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensations in the lip, tongue, chin, gums, cheeks, and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth, or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, vomiting, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

CHANGES IN TREATMENT PLAN: I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes, additions and/or deletions as the dentist deems necessary.

RELEASE OF PROTECTED HEALTH INFORMATION: I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health. I understand that in order to receive proper care, it may be necessary to use my health care information for the purpose of obtaining insurance payment for services rendered, determining insurance benefits or the benefits payable for related services. I understand that there may also be a need to consult with other health care providers for the purpose of protecting my general health.

I hereby request and authorize Family Dental Care, LLC (Dr. Erica Fisher, Dr. Kristy Fisher, and Dr. Amy Bagley), and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function, and health of my mouth, teeth, bone, and tissues, and understand the risks involved, as well as the possible alternative methods of treatment that have been fully explained to me. I also authorize the operating dentist and assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve my condition, or treat unhealthy or unforeseen conditions that may be encountered during treatment.

I understand that dentistry is not an exact science, and therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I am requesting and authorizing. In order to receive treatment, I agree that if there is any difference or disagreement between my attending dentists and myself, all efforts will be made to resolve any difference or disagreement with my attending dentist and myself. If we are unable to agree on a solution, then I agree to take the problem to a reconciliation board such as the grievance committee of my dental health plan, the Dental Society, or Missouri Dental Board and agree to accept their resolution in lieu of pursuing remedies by way of litigation, in consideration of helping to keep costs of treatment and services as low as possible. I also understand that this agreement is binding on my heirs and all other family members.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

Signature_____ Date_____

Please Print Name_____

FAMILY DENTAL CARE FINANCIAL POLICY

Welcome to our dental practice! We are committed to providing you with the best possible dental care. We believe that service to our patients is at its best when there is understanding and mutual cooperation. It is important that you understand what is expected financially before any dental treatment. Please ask if you have any questions about our fees, financial policy, or your responsibility.

Payment is due at the time of your appointment. We accept cash, checks, Visa, MasterCard, American Express, Discover and Care Credit.

In most instances we accept assignment of insurance benefits, in which case, your portion of each treatment is due at your appointment. The patient portion will be an estimate based on the information given by a representative from the patient's insurance company. This information is NOT a guarantee of payment. We will assist you in any way possible to receive payment for charges filed with your insurance. Patients are responsible for all amounts not covered by their insurance carrier.

PLEASE UNDERSTAND THAT:

1. YOUR insurance is a contract between you, your employer, and the insurance company.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to the companies who pay a percentage of dental fees. However, this statement does not apply to companies who reimburse based on a fee schedule which bears no relationship to current standard cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. This may include procedures such as additional x-rays needed by your insurance company to process your claim.
4. Should your insurance company take longer than 60 days to pay, we would ask that you take care of the balance due and be reimbursed when we receive the insurance payment.
5. Should your account be sent to a collection agency for failure to pay, you will be responsible for your balance plus a 20% collection fee.
6. Returned checks are subject to a $30 fee.
7. Any unpaid balances over 60 days are subject to 9% interest.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are YOUR responsibility from the day services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems should arise, we encourage you to contact us promptly for assistance in the management of your account.

This is a policy for all our patients and will help keep our fees more stable. If at any time you have a question or are unhappy about any treatment, fee, or service, please discuss it with us promptly and openly. We are here to help you and look forward to providing you with excellent dental care!

Thank you,
Dr. Erica Fisher, Dr. Kristy Fisher, and Dr. Amy Bagley

Responsible Party Signature_____Date_____

Print Name_____