



CONSENT FOR TREATMENT OF A MINOR WITHOUT PARENT BEING PRESENT

I, _____, give Skylight Dental Care permission to treat my child, _____, while I am not present in the office. The individual bringing my child to the appointment is, _____, and is at least eighteen years of age and is the patient's _____.

I also give this Individual permission to make decisions regarding my child's dental treatment: I understand payment is expected at the time of treatment. Please also note that children of the age 3 and up are to go to the back for x-rays, cleanings, exams and treatment by themselves, with the exception of certain circumstances, these will be determined by the office manager and the Doctor.

Parental contact information for questions regarding treatment and/or questions related to the minor:

Parent/Guardian Information:

Name: _____ Email: _____

Cell: _____ Home: _____ Work: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Signed: _____ Date: _____

Relationship to Patient:

PLEASE ATTACH COPY OF GOVERNMENT ISSUED ID



OUR FINANCIAL POLICY

Thank you for choosing Skylight Dental Care as your dental care provider. Please thoroughly read and sign our policy agreement. Payment is due in **full** at the time services are rendered to you as well as any individual for whom you are financially responsible for. Payments can be made via cash, check, credit cards, and money orders. There is also the option for flexible financing, with approved credit. We cannot bill your insurance company unless you have provided us with your complete and accurate dental insurance information. As a courtesy, we will attempt to verify your policy. Your insurance policy is a contract between you and your insurance carrier. Please make yourself aware of what your insurance plan consists of; this includes your yearly maximums and deductibles. Also, be aware that some, and perhaps all, of the services provided may be considered "non-covered" services and/or not considered reasonable and necessary under your dental insurance. Again, all co-pays and deductibles are due at time services are rendered. Insurances are filed when a social security number is provided, if you choose to not provide us with your social security number, you will be responsible for the full payment of services rendered. We require social security numbers as well as a valid government issued picture identification. They are for proper record keeping, and you will not be seen if you do not have a valid form of identification. Although treatment plans are given with an *estimated* patient balance on the date of service, it may differ from what the insurance carrier will ultimately pay. You, the responsible party, are responsible for any amount not paid by the insurance for any reason. You may receive a statement/invoice reflecting the balance due which will be due immediately upon receipt. In addition, maximum service charges will be charged in the event that a payment made via check, electronic authorization or debit is returned. In the event that you choose to discontinue treatment, including but not limited to, partials, dentures, crowns, bridgework and surgical preparatory work, you will remain responsible for paying all lab related costs. All accounts not paid upon becoming due will result in you, the responsible party, being sent to collections, which in turn results in being reported to credit bureaus, collection agency fees, reasonable attorney fees, and court costs. In the event that your records are needed and are not sent directly to another provider, there will be a charge of \$15.00 for copies of x-rays, and if treatment information is needed there will be an additional \$5.00 fee, or the maximum amount allowed by law or your insurance carrier. Fees are subject to change without notice.

MISSED APPOINTMENTS

Appointment times are reserved especially for you and for whom you are financially responsible for. If you are more than 15 minutes late, for any reason, you may be requested to reschedule your reservation and be charged the **\$75.00** (based on insurance guidelines) missed appointment fee. This fee will also be charged if you fail to show to an appointment. Skylight Dental Care **requires at least 24 hours notice** if you need to cancel or reschedule your reserved time. Due to high request volume, any failed afternoon appointments may result in loss of privilege to schedule at these times.

I have thoroughly read, understand and agree to the above terms and conditions.

Printed Name

Patient Name (if guardian is signing)

Signature of Patient (or authorized guardian)

Date

Relationship to patient



Patient Registration Form:

Patient Information/Información del Paciente:

Date/Fecha: _____

(Last Name, First Name and Middle Initial / Apellido, Nombre)

(Date of Birth/ Fecha de Nacimiento)

SS# / Numero de Seguro Social

E-Mail / Correo Electrónico

Address/ Dirección

City/Ciudad

State/Estado

Zip/Código Postal

Phone Number / Numero de Teléfono

Alternate Phone Number/ Numero Secundario

EXT.

Emergency Contact:

(Last, First and Middle Initial / Apellido, Nombre)

Phone Number / Numero de Teléfono

Responsible Party Information (If other than the patient) / Información de la Persona Responsable por el Paciente (Solo necesario llenar esta sección si usted no es el paciente) :

(Last Name, First Name and Middle Initial / Apellido, Nombre)

(Date of Birth/ Fecha de Nacimiento)

Relationship to Patient / Relación con el Paciente

E-Mail / Correo Electrónico

Address/ Dirección

City/Ciudad

State/Estado

Zip/Código Postal

Phone Number / Numero de Teléfono

Alternate Phone Number/ Numero Secundario

EXT.

Insurance Information/ Información de Seguro:

Self Pay/ No tengo Seguro Medicaid/Seguro dental proveído por el Gobierno PPO Insurance/ Seguro PPO

Insurance Company / Nombre de Seguro Dental

Subscriber Id/ Numero de Miembro

SS# / Numero de Seguro Social

Employer / Empleador

Group # / Numero de Group

Ins. Phone # / Teléfono de Seguro

(Subscriber Last, First and Middle Initial / Apellido y Nombre del encargado del Seguro)

(Subscriber Date of Birth/ Fecha de Nacimiento del encargado de Seguro)



Privacy HIPAA Consent Form

I _____, give _____ permission

(Name of Patient)

(Name of Authorized Individual)

to discuss any appointments and/or treatment related to my care as well as pick up any documents/cases on my behalf. This consent will be valid as of _____ unless revoked in writing to Skylight Dental Care, or myself. (Date)

Signature

Date

Printed Name

Eaglesoft Medical History(Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?

Women: Are you...

Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic
Metal Latex Sulfa Drugs Local Anesthetics
NO ALLERGIES

Do you use controlled substances?
Other?

Do you have, or have you had, any of the following?

AIDS/HIV Positive
Alzheimer's Disease
Anaphylaxis
Anemia
Angina
Arthritis/Gout
Artificial Heart Valve
Artificial Joint
Asthma
Blood Disease
Blood Transfusion
Breathing Problems
Bruise Easily
Cancer
Chemotherapy
Chest Pains
Cold Sores/Fever Blisters
Congenital Heart Disorder
Convulsions
Yellow Jaundice
Cortisone Medicine
Diabetes
Drug Addiction
Easily Winded
Emphysema
Epilepsy or Seizures
Excessive Bleeding
Excessive Thirst
Fainting Spells/Dizziness
Frequent Cough
Frequent Diarrhea
Frequent Headaches
Genital Herpes
Glaucoma
Hay Fever
Heart Attack/Failure
Heart Murmur
Heart Pacemaker
Heart Trouble/Disease
Autism
Hemophilia
Hepatitis A
Hepatitis B or C
Herpes
High Blood Pressure
High Cholesterol
Hives or Rash
Hypoglycemia
Irregular Heartbeat
Kidney Problems
Leukemia
Liver Disease
Low Blood Pressure
Lung Disease
Mitral Valve Prolapse
Osteoporosis
Pain in Jaw Joints
Parathyroid Disease
Psychiatric Care
ADD/ADHD
Radiation Treatments
Recent Weight Loss
Renal Dialysis
Rheumatic Fever
Rheumatism
Scarlet Fever
Shingles
Sickle Cell Disease
Sinus Trouble
Spina Bifida
Stomach/Intestinal Disease
Stroke
Swelling of Limbs
Thyroid Disease
Tonsillitis
Tuberculosis
Tumors or Growths
Ulcers
Venereal Disease

Have you ever had any serious illness not listed above?

Comments:

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:
Date: