HAMILTON CO. PEDIATRIC DENTISTRY

Child's Name: ____ Preferred Name: ______________

Reason for Visit: ____

Address: ____ Date of Birth: ____/____/_______
(street)

____ Gender: Male Female
(city) *(state)* *(zip)*

Home Phone: (_____) ____ Grade in School: _______________

Siblings: ____ Hobbies: _____________________

A few words to describe your child: ____

Parent's Name: ____ Legal Guardian? Yes No

Place of Employment and Occupation: ____

Email Address: ____

Primary Phone: (_____) ___________________________________ Home Work Cell

Secondary Phone: (_____) _________________________________ Home Work Cell

Address: ____ Date of Birth: ____/____/_______
(street)

____ Social Security # _______________
(city) *(state)* *(zip)*

Parent's Name: ____ Legal Guardian? Yes No

Place of Employment and Occupation: ____

Email Address: ____

Primary Phone: (_____) ___________________________________ Home Work Cell

Secondary Phone: (_____) _________________________________ Home Work Cell

Address: ____ Date of Birth: ____/____/_______
(street)

____ Social Security # _______________
(city) *(state)* *(zip)*

Laura Juntgen, DMD, MSD, Diplomate
13430 North Meridian Street, Suite 165 Carmel, IN 46032
Phone (317) 846-5893 Fax (317) 846-5878
www.hcpdent.com

HAMILTON CO. PEDIATRIC DENTISTRY

Treatment Consent

A child under the age of 18 cannot legally consent to dental treatment. I confirm that I am the legal guardian of the child listed, and I give my consent for Dr. Laura Juntgen and the staff of Hamilton County Pediatric Dentistry to treat my child.

Signature: ____ Relationship: _________________________

Printed Name: ____ Date: ______________________________

You may designate another family member or adult to bring your child to scheduled appointments. ***However***, we reserve the right to contact the child's legal guardian prior to any appointment. Failure to reach a legal guardian may result in rescheduling. Please designate the name of individuals that may bring your child to subsequent dental appointments:

Name: ____ Relationship: _________________

Name: ____ Relationship: _________________

Hamilton County Pediatric Dentistry is a Delta Dental Premier provider. We do not participate with any other PPO or HMO plans. However, as a complimentary service, we will file your child's appointment with another insurance company for any potential out-of-network reimbursement. All services not covered by your insurance company are subject to collection at the time of service.

Do you have dental insurance that we may file on your behalf? Yes No

Dental Insurance Company: ____

Name of Policy Holder: _____________________________________ Policy Number: _______________

Financial Policy, Cancellation Policy and Consent

Should at any time my account become delinquent (90 days past due), I am responsible for all fees that may incur when trying to collect the debt. Insurance payments are ordinarily received within 30-60 days from the time of filing. If my insurance company has not made a payment within 60 days, I am responsible for contacting my insurance company. If payment is not received or the claim is denied, I am responsible for paying the full amount at that time. In the event of default of payment, reasonable collection agency fees equal to 25% of the delinquent balance and reasonable attorney fees shall be added to the amount on the account, plus any applicable court costs. **I understand that dental appointments will be limited to emergency appointments <u>only</u> for any account greater than 90 days past due. I consent to full financial responsibility of this account. Please note, our office requires a minimum of 24 hours advanced notice of cancellation.** Failure to provide advanced notice may result in an appointment failure fee and/or restricted future scheduling.

Signature: ____ Relationship: _________________________

Printed Name: ____ Date: ________________________________

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