Welcome to Aurora Dental Care ~ Child Info

We strive to make your dental visits pleasant and comfortable.
Our goal is to teach you oral habits which will help you to achieve and keep Healthy Teeth and Gums for Life!

Today's date: _____

Full Name: _____ Prefer to be called:_____

Childs Birth Date: _____Age_____ Sex: M F Child's SS# _____

Child's Home Address: _____ Zip Code: _____

Child's Home Phone # _____ E-mail for Child's appts:_____

School:_____ Grade:_____

Hobbies/ Sports: _____

How did you hear about Aurora Dental Care? _____

PARENT INFORMATION

Who is responsible for this Account? _____

Father Step Father Guardian

Father's Name: _____DOB: / /

Address: (if different from child's)

_____

Email: _____ Cell: _____

SS#: _____ DL#: _____

Wk# (_____) _____ Hm#: _____

Employer: _____ Occupation: _____

Employer Add _____

If Dental Insurance for your child, fill out below:

Insurance Co. Name: _____

Insurance Address: _____

Insurance Phone #: _____

Group # (Plan, Local, or Policy #): _____

Mother Step Mother Guardian

Mother's Name: _____DOB: / /

Address: (if different from child's)

_____

Email: _____ Cell: _____

SS#: _____ DL#: _____

Wk# (_____) _____ Hm#: _____

Employer: _____ Occupation: _____

Employer Add _____

If Dental Insurance for your child, fill out below:

Insurance Co. Name: _____

Insurance Address: _____

Insurance Phone #: _____

Group # (Plan, Local, or Policy #): _____

INSURANCE AUTHORIZATION/PAYMENT AGREEMENT

I authorize and request my insurance company to directly pay Aurora Dental Care for claims submitted on behalf of my self/ child/children. I understand my insurance may pay less than the actual bill for services. I agree to be completely responsible for payment of all services rendered on behalf of my self/child/children.

If I do not pay the entire balance within 30 days of the monthly billing date, a late fee of 1.8% APR will be accessed each month. I realize that failure to keep this account current may result in Aurora Dental Care being unable to provide dental services except for emergency treatment. In the case of default of payment on this account, I agree to pay all collection costs and attorney fees incurred in attempting to collect this debt.

X _____ Date: _____

Signature

AURORA DENTAL CARE FINANCIAL POLICY (Important! Please Read)

Welcome to Aurora Dental Care, Thank you for choosing us as your dental care providers. We are committed to providing outstanding dental care in a comfortable and relaxed environment. We use modern technology and high quality materials ensuring patients receive the best dental treatment available today. The following is a statement of our office and financial policies which we request that you read and sign prior to any dental treatment.

Full payment for services rendered is due at the time of service (unless prior payment arrangements have been made). We accept cash, personal checks, Visa, MasterCard, Amex, Discover and Care Credit.

Dental Insurance: We understand the value of your insurance benefits and will assist you in obtaining your maximum benefits. We cannot bill your insurance company unless you give us the correct information. We may accept an assignment of insurance, however you are responsible for co-pays and deductibles at the time services are rendered. We also require a credit card on file in the event of a remaining balance once insurance benefits are received.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do not receive your insurance payment in full within 45 days from the date services are rendered, the balance will be automatically billed to you for immediate payment. Our estimate of insurance payment is not a guarantee of payment by your insurance company. The final payment is determined at the time your claim is received and reviewed by your insurance company.

Major Procedures/Treatment: Our office offers a 5% prepay discount on services of $300 or more when payment is made by cash or check and a 3% prepay discount on services of $300 or more when payment is made by Credit Card. Care Credit or any other third party/interest free financing cannot be used with this option.

Service Charge: In the case of default of payment, the patient or responsible party promises to pay any legal interest on balance due, together with any collection costs and reasonable attorney fees incurred to the effect to collection of this account or future outstanding accounts.

Missed Appointment: We respect the value of our patient's time. Every effort will be made to accommodate each patient at their scheduled time. We recognize that at times there may be a cancel or reschedule an appointment; therefore we ask that you contact the office 24 hours in advance when you cannot keep your scheduled appointment. If you do not cancel or reschedule your appointment at least 24 hours in advance, our policy is to chared a missed appointment fee of $50. Please help us to better serve you and all our patients by keeping your scheduled appointments.

I have read and understand the financial and office policies, and agree to this term

_____ Date _____

Signature of Patient or Responsible Party

Payment Authorization:

I authorize Aurora Dental Care to:

□ Please keep this signature on file for any estimated patient portion due at the time of service.

□ Please keep this signature on file for any estimated patient portion due at the time of service and any unpaid balance after insurance payment.

□ Please Call me before charging my card

□ Please send me a receipt

Visa MC Discov AmEx CareCred

Name as it appears on CC card:

_____

Card # _____

Exp Date: _____CVD#_____

Billing Zip: _____

_____

Card Holder Signature:

Aurora Dental Care

Aurora Dental Care CHILD Medical History

Dental History

Has your child ever been evaluated or had orthodontic treatment before?	○ Yes ○ No	If yes
Have there been any injuries to the face, mouth or chin?	○ Yes ○ No	If yes
Does the child require antibiotics before dental treatment?	○ Yes ○ No	If yes
Have adenoids or tonsils been removed?	○ Yes ○ No	If yes
Does your child have any missing or extra permanent teeth?	○ Yes ○ No	If yes
Has this child ever had any pain/tenderness in his/her jaw joint? (TMJ/TMD)	○ Yes ○ No	If yes
Does this child brush his/her teeth daily?	○ Yes ○ No	If yes
Does this child floss his/her teeth daily?	○ Yes ○ No	If yes
Do you have a Primary Care Physician for this child?	○ Yes ○ No	If yes
Is this child currently under the care of a physician?	○ Yes ○ No	If yes
Has puberty begun?	○ Yes ○ No	If yes
Has menstruation begun?	○ Yes ○ No	If yes
Please describe the child's current physical health	○ Good ○ Fair	
Is this child currently taking any medications?	○ Yes ○ No	If yes

Is this child allergic to:	○ Yes ○ No
Latex	○ Yes ○ No
Metals	○ Yes ○ No
Sulfa Drugs	○ Yes ○ No
Aspirin	○ Yes ○ No
Local Anesthetics	○ Yes ○ No

Seasonal, Pet, Food?	○ Yes ○ No	If yes
Other?	○ Yes ○ No	If yes

Has this child ever experienced the following medical problems?

Abnormal bleeding	○Yes ○No	Convulsions	○Yes ○No	Kidney Problems	○Yes ○No
ADD/ADHD	○Yes ○No	Diabetes	○Yes ○No	Liver Problems	○Yes ○No
Epilepsy	○Yes ○No	Mitral Valve Prolapse	○Yes ○No	Hospital Stays/Operations	○Yes ○No
Artificial Bones/Joints, Valves	○Yes ○No	Rheumatic Fever	○Yes ○No	Asthma	○Yes ○No
Heart Murmur	○Yes ○No	Cancer	○Yes ○No	Hemophilia	○Yes ○No
Sickle Cell Disease/Traits	○Yes ○No	Congenital Heart Defect	○Yes ○No	Hepatitis	○Yes ○No
Tuberculosis	○Yes ○No	Handicaps/Disabilities	○Yes ○No	Prosthetics	○Yes ○No
Scarlet Fever	○Yes ○No	Hearing Impairment	○Yes ○No		

HIV/AIDS ○Yes ○No

Are the child's immunization's current? ○Yes ○No If yes

Is there anything you would like to discuss with the Doctor in private? ○Yes ○No If yes

Does this child have any serious medical problems? ○Yes ○No If yes

Does/Did the child have any of the following habits?

Breast Fed	○Yes ○No	
Clenching/Grinding Teeth	○Yes ○No	
Lip Sucking/Biting	○Yes ○No	
Mouth Breather	○Yes ○No	
Nail Biting	○Yes ○No	
Nursing Bottle Habits	○Yes ○No	
Speech Problems	○Yes ○No	
Thumb/Finger Sucking	○Yes ○No	
Tongue Thrust	○Yes ○No	
Used Pacifier	○Yes ○No	
Has your child play or played a musical instrument?	○Yes ○No	If yes

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 child's health. It is my responsibility to inform the dental office of any changes in the medical status.

Signature of Patient, Parent or Guardian:

x _____