

Dr. Angela Wandera & Associates

Pediatric Dentistry and Orthodontics

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PATIENT NUMBER

PATIENT INFORMATION

Child's Full Name _____ Nickname _____
First Last Middle Initial
Date of Birth _____ Male [] Female [] Pets/Interest _____
Brothers/Sisters _____

PARENT/LEGAL GUARDIAN RESPONSIBLE FOR ACCOUNT *(Must be parent signing consent today)*

Name _____ Relationship to Patient _____
Marital Status _____ Driver's License # _____
Home Address _____ City _____ State _____ Zip _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
How Did You Find Out About Our Practice/Who May We Thank for This Referral? _____
Someone Not Living With You to Notify in Case of Emergency _____

Although this office is sensitive to the issues of identity fraud and theft, most dental insurance includes the policy holder's social security number as necessary information to process claims. Please contact your insurance company to determine if the number is required. If it is not necessary for the claims process, please indicate this on the registration form. If you are uncomfortable providing the policy holder's social security number and we cannot submit your claim without this information, we ask that you take responsibility for submitting the claim yourself. Additionally, it will be necessary for this office to collect payment directly from you on the day of service. Thank you for your understanding.

PRIMARY DENTAL INSURANCE COVERAGE

Name of Insured _____ Relationship to Patient _____
Social Security # _____ Date of Birth _____
Home Address _____ City _____ State _____ Zip _____
Employer _____ Position Held _____ How Long _____
Employer Address _____ City _____ State _____ Zip _____
Name of Insurance _____ Address _____
Group/Policy # _____ Phone Number _____

SECONDARY DENTAL INSURANCE COVERAGE

Name of Insured _____ Relationship to Patient _____
Social Security # _____ Date of Birth _____
Home Address _____ City _____ State _____ Zip _____
Employer _____ Position Held _____ How Long _____
Employer Address _____ City _____ State _____ Zip _____
Name of Insurance _____ Address _____
Group/Policy # _____ Phone Number _____

OVER

PERSONAL AND INSURANCE INFORMATION

LATE/FAILED APPOINTMENT POLICY

If you arrive more than 15 minutes late for the scheduled appointment, it may be necessary to reschedule the visit. This is to ensure quality and efficient care and service to all patients and their families. Two failed appointments or cancellations without a 24 hour notice will result in restrictions in future appointments. In signing the consent below, you express understanding and acceptance of this late appointment policy.

MINNESOTA STATUTES 144.292 "PATIENT RIGHTS"

Disclosures of health records may be made without written consent of the patient to the Commissioner of Health or the Health Data Institute and in a medical emergency. Disclosures with written consent are made to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

You have a right to access and to obtain copies of your child's records and other pertinent information maintained by this office. When records are required for transfer purposes, a duplication charge of \$15 may apply.

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my child's records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I have also reviewed the "Patients Rights" clause regarding disclosures and accept the office policy on duplication charges.

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to Dr. Angela Wandera & Associates of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payer. A \$35 charge will be assessed on all unpaid and returned checks.

I attest to the accuracy of the information on this page.

SIGNATURE _____ **DATE** _____