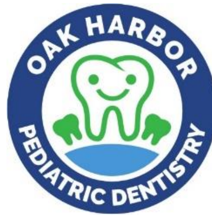


Peter LF Cao, DMD, FRCDC, Oak Harbor Pediatric Dentistry

Get- Acquainted Questionnaire

Child's Name_______________________________ Preferred Name______________ DOB______________M/F___
email____

Father's Name____ Social Security No.__________

Mother's Name____ Social Security No.__________

Home Address ____

Home Phone___________________Cell Phone__________ School_______________________________ Grade______

Emergency Contact

Name____________________________________ Relationship___________________________Phone______________

Name and Ages of other children in the family

Name____ DOB______________ Seen at this office? ______

Name____DOB_______________Seen at this office? ______

Name ____ DOB______________ Seen at this office? _____

Father's Occupation___________________________________ Work Phone________ Military? ________Rank______

Name of Employer____ City__________________

Mother's Occupation___________________________________Work Phone___________Militayr ? ____ Rank_______

Name of Employer____ City__________________

Person Responsible for this account: Name____

Address (Street/city/state/zip)____

Does child live with person responsible for account ☐ Yes ☐ No Is child a foster child/ adopted ☐ Yes ☐ No

Primary Dental Insurance Carrier

Insurance Company_____________________________________ Addresss______________________________

Employee covered under this plan______________________________Social Security/ID #_________________

Birthdate_______________Group No.________________________ Union or Local No.______________________

Relationship to child________________________________Effective date________________________

Secondary Dental Insurance Carrier

Insurance Company_______________________________________Address_______________________________

Employee covered under this plan______________________________Social Security/ID #___________________

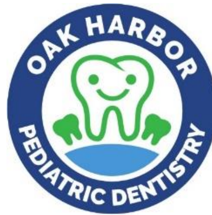
Birthdate___________________Group No.______________________Union or Local #__________________
Relationship to child_____________________________ Effective date________________________
Who may we thank for referring to our office? ____

Oak Harbor Pediatric Dentistry may contact me via phone, text and /or email as needed to ensure accurate patient scheduling a nd information as available for their dental appointments and/ or dental health needs.

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan for additional treatment , I also agree to the use of anesthetics and pre medications considered necessary or advisable by the dentist for the comfort and wellbeing of the child.

I understand that it is my responsibility to inform the office of any changes to my insurance. I also understand that I am in contract with the insurance and it is my responsibility to verify eligibility with this office before the a ppointments. Finally, I accept full financial responsibility for my child's account regardless of my ability to be reimbursed by insurance, ex-spouse or any other third party.

Parent or Legal Guardian____ Date_________________________



Peter LF Cao, DMD, FRCDC, Oak Harbor Pediatric Dentistry

Financial Agreement

Our goal at Oak Harbor Pediatric Dentistry is to help your make the best decisions concerning your child's dental health and to provide quality dental care. At your child's visit we will discuss proposed treatment, cost involved and any alternative treatments. Estimates given at the appointment are valid for 90 days and are only ESTIMATES of what your insurance coverage will be. Treatment may change during the appointment to provide the best possible care for your child, at which time you will be notified of your change in financial liability.

We CANNOT guarantee the amount the insurance company will pay. We do our best to provide you with the most accurate information but it is your responsibility to notify us of any changes that have occurred. If there is a dispute with your insurance company, we will assist you in resolving the problems, but the responsibility for resolving the problem remains with you, the subscriber. During this time we do expect payment of your account.

Payment for the estimated amount not covered by the insurance is due on the day of treatment. We accept cash, check, Visa, Master card, or Discover Card. Please advise us of your payment concerns prior to your child's appointment. Once the insurance company has processed your claims, we will advise you of any differences and will refund any over payment or send you a statement for any remaining balance due. Please be aware any balance that is unpaid is subject to interest charge and if payment is not received within 90 days, the account will be subject to collections. There is also a $40 charge for any checks returned for insufficient funds.

MISSED APPOINTMENTS

It is important for you to keep your scheduled appointments for the health of your child. We do understand that situations occur that prevent you from coming in, however we ask that you give us a 24 hour notice of changing appointment. **If there is repeated missed or late cancelled appointments the patient will be subject to dismissal from the practice.**. If notice is not given 24 hours before, accounts with private insurance will be subject to a:

- **$25 fee for a missed/ late cancelled hygiene appointment ***
- **$50 fee for a missed/ late cancelled restorative appointment(including sealants)***
- **$125 fee for a missed anesthesiologist appointment * ****

*These charges are per family member. Illnesses and emergencies do not incur a fee.

Parent or Legal guardian____ Date___________________

Peter LF Cao, DMD, FRCDC

Larry E Hartman, DDS, MS

Silent observer agreement

Here at Oak Harbor Pediatric Dentistry we happily welcome **one** parent/guardian to accompany their child in the clinic during treatment. In order for us to continue offering this as an option we require all parents read and sign this agreement stating that the below guidelines will be followed at every visit.

Please decide prior to appointment(s) which **one parent/guardian** will be present in the clinic during treatment; this is due to the limited seating. Having too many people in the clinic can be overwhelming for the patient, staff and doctor.

Due to HIPPA guidelines, we ask that no pictures or video recordings are taken during treatment. Additionally, we require all children who aren't being seen for an appointment today have *constant supervision* in the reception area. No children under the age of 13 are to be left unattended. Please note: children 13 and under may not be responsible for younger children in the reception area; we require that a parent be present to care for younger children at all times.

If you choose to accompany your child you will not be permitted to walk in and out of the clinic or around the office. We ask that you remain seated throughout the duration of the appointment. We also ask that for the safety of your child, you do not stand over the doctor or assistants during treatment.

Our staff devotes treatment time to your child. We understand that parents can offer emotional support during procedures but we ask that you be a silent observer. This ensures that we can focus on your child and offer them quality care without distractions. **We also ask that anything you see or hear in this office does not leave this office. Some of this material may be sensitive to other individuals and out of respect to those around you, we ask that you do not share personal information.**

Thank you for trusting Apple Pediatric Dentistry with your child's dental care needs. We look forward to a great visit!

"I understand that by signing this document I am agreeing to all guidelines stated, all my questions have been answered to my satisfaction and I willingly give my consent to be a "Silent Observer" in this office"

Dependent name(s):____

Parent Signature:_____________________________________ Date:___________________

Peter LF Cao, DMD, FRCDC

Patient Name:

Date:

Oak Harbor Pediatric Dentistry is requesting your permission to utilize the photos taken of your child(ren).

We would like to ask your permission to potentially use your photos for articles, our web site, Facebook, advertisements, office brochures and educational purposes.

By signing this agreement, you are giving us your permission to use the photos that we take of your child(ren). If at any time you do not want your child’s picture taken or shared, please let us know.

Thank you!

Printed:

Signed:

Relationship: