Pediatric Dentistry of the Treasure Coast

To assist us in keeping _____'s records current, please answer the following questions: Cell Phone#_____

Please provide us with your email address:_____ Emergency contact phone. Name _____ #_____

1. Has your address or telephone/cell changed? ☐ YES; ☐ NO

2. Has your insurance changed? ☐ YES; ☐ NO

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3. Has your employment changed? ☐ YES; ☐ NO

Employer_____

4. Has your child's medical history changed? ☐ YES; ☐ NO

If yes list changes. _____

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5. Are there any un-usual medical treatments? ☐ YES; ☐ NO
(Contemplated or taken place since last visit.)

6. Is your child currently taking any medications? ☐ YES; ☐ NO
Please List if yes.

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7. Is your child using/taking fluoride vitamins, Clin Pro, or Xylitol? ☐ YES; ☐ NO

8. Have there been any dental problems. ☐ YES; ☐ NO

9. Do you feel home care has been adequate since last visit? ☐ YES; ☐ NO

10. Any suggestions or comments to improve our office? ☐ YES; ☐ NO

The undersigned authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until canceled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred in this child for dental treatment regardless of insurance coverage. To avoid surprises on your dental bill, it is important you understand what your insurance will cover. All dental plans are the result of a contract between your employer and an insurance company**. We at no time guarantee what your insurance will or will not do with each claim. I fully understand this consent and have no further questions.**

SIGNED RELATIONSHIP DATE:

Credit Card Payment Authorization

I authorize charges to my credit card on file. You will be charged the amount of the insurance portion that has not been paid after Dr. Arias has received the EOB from your insurance company. Any amount under $100.00 will be charged to the credit card on file. Any charges over $100.00 you will be contacted before the card is charged. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. I understand a $2.00 charge may be applied and refunded back to your card within 3 to 5 days to authorize legitimacy.

I _____ authorize Pediatric Dentistry of the Treasure Coast to (Cardholder's Name) charge my

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Account/CC Number _____

Expiration Date ____ /____

CVV ____

Zip Code _____ .

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Pediatric Dentistry of the Treasure Coast in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

(Cardholder's Signature)

Financial arrangements only

Credit Card Payments for Payment Arrangements/ Orthodontics and approved Financial Arrangements only

$_____ on the _____ of each _____.(week, month, etc.)

(Amount $) (day)