Tell us about your child…

Date:_____/_____/_____

Patient Name: _____
Last, First MI Preferred/Nickname

Date of Birth: _____/_____/_____ Social Security # *(for insurance purposes)*: _____

*Sex: ☐ Male ☐ Female *with whom does the child live with? ☐ Mom ☐ Dad ☐ Other_____

Parent Information:

Parent Information	Mother	Father
Name:		
Street Address:		
City, State and Zip Code:		
Home Phone:		
Cell Phone:		
Email:		
Birth Date:		
Social Security #:		
Employer:		
Work Phone:		

Is the child a college student? ☐ No ☐ Yes If yes: ☐ Full-time ☐ Part-time

Does the child have Dental Insurance? ☐ No ☐ Yes

Primary Insurance Company: _____

Name of Subscriber: _____ Subscriber's Date of Birth: _____/_____/_____

ID #: _____ Relationship to patient: _____

Is there secondary coverage for the child? ☐ No ☐ Yes

Please take note…

- A charge of $25.00 will be assessed for all returned checks.
- We reserve the right to charge $30 for appointments cancelled or broken without 24 hours advance notice.

Legal Guardian Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Separated

Please turn over

How did you hear about our office?

☐ Family/Friend: _____ ☐ I live in town/Drive by your office ☐ Google/Internet search ☐ Event: _____

☐ I received your mail ☐ Other (Please list): _____ ☐ What made you decide to come in? _____

...

HIPAA Privacy Patient Consent:

- ❑ I have read a copy of this office's Notice of Privacy Practices.
- ❑ I have chosen not to read a copy, but I am aware of this office's privacy practices.

With whom may we discuss your dental health and/or account with? _____

Relationship to Patient: _____

**Without this written consent, we cannot discuss your treatment or account with anyone other than you.*

I certify that I have read and understand this form as well as my financial responsibilities, and that I have the right to ask questions before agreeing to any procedure(s). I understand further that I have the right to be provided with answers to questions that may arise during the course of my treatment. I am aware that the practice of dentistry is not an exact science and I acknowledge that no written or oral representations, warranties or guarantees have been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers, demonstrations and/or presentations certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

By signing this you are accepting financial responsibility of this account

_____ _____

PRINT Name of Parent or Guardian Relationship to Patient

_____ _____

Signature of Parent or Guardian Date

Robinson DENTAL

Family caring for family…

Dr. Elizabeth Robinson, DDS
Dr. Scott Robinson, DDS
Dr. Malavi Patel, DMD
Dr. Derek DeVries, DDS
Dr. Jake Streng, DDS
Dr. Alex Hoelzel, DDS
Dr. Jeff Cartwright DDS
Dr. Steve Feddick DDS

502 W. Randall St
Coopersville, MI 49404

899 Reno Drive
Wayland, MI 49348

888-WE-C-U-NOW
888-932-8669

info.robinsondental@gmail.com

**I give my consent to Robinson Dental for treatment of my child. I authorize my insurance benefits to be paid directly to Robinson Dental. I realize that I am responsible to pay non-covered services and/or any co-pay/deductible. Payment is due at the time of services rendered. If for some reason my account is sent to a collection agency or an attorney for non-payment, I agree to pay all collection and court costs, attorney fees, and other costs incurred. I hereby authorize the release of pertinent medical information to insurance carriers for payment purposes. I am aware that it is my obligation to know my insurance company's policies and coverages.

****Billing and Insurance:** Our professional relationship is with you, and not with any insurance carrier. You are responsible for paying the full cost of treatment when it is rendered unless it is covered by insurance. We accept most major insurance companies and we will submit all authorized claims to the designated insurance carrier, provided we have received all required information. For your convenience, we will request verification of your co-pays and deductible from your insurance carrier. It is your responsibility to confirm your co-pay and deductible, and to make required payments at the time of each appointment (we accept cash, personal check, Visa, MasterCard, Discover and Care Credit). We will charge a $25.00 fee for any returned check. Note that quoted deductibles and co-pays are provided by your insurance carrier as **estimates only, and do not guarantee payment** by your insurance carrier. Some services or treatments might not be covered benefits under your insurance plan. You are responsible for payment of any services or treatments not covered by your insurance carrier.

****Missed Appointments:** You will not be billed for missed appointments if you give us at least 24 hour notice of cancellation, so that we can schedule another patient. Failure to give a 24 hour notice, or a no call/no show will result in a $30.00 charge.

****Past Due Account**: Accounts not paid within 30 days are considered past due. You are responsible for payment of any costs we incur in collecting past due accounts (such as collection agency and attorneys fee). Effective June 1st, 2015, all outstanding balances older than 90 days will be subject to a 6% monthly finance charge.

I understand and agree to the terms of this document, I authorize Robinson Dental to bill my insurer(s) for all services rendered and I authorize my insurer(s) to make payment directly to Robinson Dental.

This authorization will be effective for a period of one year from the date of signing.

Child's name: _____

X_____ Date_____/_____/_____

Signature of Responsible Party **(must be over 18 years old)**