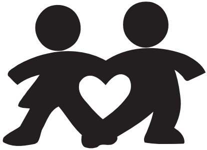

INSURANCE INFORMATION

for

Scott W. Nieman, D.D.S., Inc.

As a service to you we will be happy to process your child's dental claims. However, without the following information we will need you to pay at the time of service.

PRIMARY INSURANCE

Name of Insured: (Employee) ______________________ First Middle Last **Birth Date:** ____ - ____ - ____ Month Day Year

Insurance ID Number: ______________________ **Social Security No.:** ____ - ___ - _____

Employer: ______________________

Dental Insurance Company Name: ______________________ **Group No.** __________

Dental Insurance Company Address: ______________________
Street

______________ City ________ State __________ Zip

______________ Phone

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I FURTHER AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

Signed X ______________________ Date __________
(PATIENT OR PARENT IF MINOR)

SECONDARY INSURANCE

Name of Insured: (Employee) ______________________ First Middle Last **Birth Date:** ____ - ____ - ____ Month Day Year

Insurance ID Number: ______________________ **Social Security No.:** ____ - ___ - _____

Employer: ______________________

Dental Insurance Company Name: ______________________ **Group No.** __________

Dental Insurance Company Address: ______________________
Street

______________ City ________ State __________ Zip

______________ Phone

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I FURTHER AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I ALSO UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

Signed X ______________________ Date __________
(PATIENT OR PARENT IF MINOR)

Patient Name ______________ **Birthdate** ___/___/_____ **Today's Date** ___/___/_____

Child's Physician ______________ Physician's Phone ______________

Whom may we thank for referring you? ______________

Purpose of today's visit: ______________

Is this your child's first dental visit? ❑ Yes ❑ No

If not, date of last dental visit: ______________ Previous dentist ______________

Child's Address ______________ Date of Birth ______________
(street) (city) (zip)

Mother's Name ______________ Home Phone ______________ Cell Phone ______________

Mother's Social Security Number ______________ Date of Birth ______________

Mother's Address (if different) ______________

Mother's Employer ______________ Occupation ______________

Business Phone ______________ Ext. ______________

Father's Name ______________ Home Phone ______________ Cell Phone ______________

Father's Social Security Number ______________ Date of Birth ______________

Father's Address (if different) ______________

Father's Employer ______________ Occupation ______________

Business Phone ______________ Ext. ______________

❑ married ❑ divorced ❑ widowed ❑ single

School child attends (if applicable) ______________

Extracurricular activities (if applicable) ______________

Name ______________________

Medical History

	YES	NO		YES	NO
Is your child in good health?	❑	❑	Has your child had regular medical check-ups?	❑	❑

Does your child have any of the following:

	Yes	No		Yes	No		Yes	No		Yes	No
Epilepsy or Seizures	❑	❑	Diabetes	❑	❑	Vision Problems	❑	❑	Hearing Abnormalities	❑	❑
Heart Condition	❑	❑	GI Disorder	❑	❑	HIV-AIDS	❑	❑	Disabilities/Handicaps	❑	❑
Heart Murmur	❑	❑	Asthma	❑	❑	Hepatitis	❑	❑	Developmental Delay	❑	❑
Kidney or Liver Problems	❑	❑	ADD / ADHD	❑	❑	Down's Syndrome	❑	❑	Sensory Issues	❑	❑
Bleeding Problems	❑	❑	Tuberculosis	❑	❑	Bone/Joint Problems	❑	❑			
Other: ____________	❑	❑									

If yes to any, please explain ______________________

Any Allergies to Medication? ______________________

other Allergies (hay fever, food,etc.) ______________________

Any serious illness, surgery, or hospitalization? ______________________

Medications with Dosages ______________________

Dental History

Fluoride	YES	NO
Fluoridated drinking water?	❑	❑
Using Fluoride toothpaste?	❑	❑
Taking Fluoride prescription?	❑	❑
Using Fluoride rinse? (ie. ACT)	❑	❑

Oral Hygiene

At what age did you start brushing child's teeth? ____________

Are you still brushing for your child? ❑ Yes ❑ No

Are your child's teeth being flossed daily? ❑ Yes ❑ No

General

Has your child experienced any sensitivity or pain with their teeth? ❑ Yes ❑ No
if yes explain ______________________

Does your child have any oral habits? (pacifier, finger sucking, grinding, etc.) ❑ Yes ❑ No
if yes explain ______________________

Has your child experienced any oral injuries? ❑ Yes ❑ No
if yes explain ______________________

Has your child experienced any unfavorable medical or dental experiences? ❑ Yes ❑ No
if yes explain ______________________

Do you or your child have any dental concerns? ❑ Yes ❑ No
if yes explain ______________________

PHOTO RELEASE

I, the undersigned, do hereby relinquish any and rights to photographs, portraits, transparencies, prints, or other photographic reproductions captured with still, motion picture, video, digital or other cameras for use by this office.

CONSENT FOR DENTAL TREATMENT

I request and authorize Drs. Nieman, Barber, Baran and their staff to examine, clean,and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the doctor to diagnose and/or treat my child's dental problem. I will allow photographs of my child or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Drs. Nieman, Barber, Baran and their staff will provide an environment designed to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

I have reviewed the information on the Health History Form and it is accurate to the best of my knowledge. I undrestand that this informarion will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I agree to inform this office of any changes in address, phone, employment, etc., that occur during the course of treatment for my child. If the patient is a minor, it is necessary that signed permission be obtained from a parent or legal garden before any dental services can be rendered. I understand that I will be responsible for any charges incurred on this child for dental treatment.

______________ Date

______________________ Signature of Responsible Party

SCOTT W. NIEMAN, D.D.S., INC.

PEDIATRIC DENTISTRY

Scott W. Nieman, D.D.S.
Carolyn A. Barber, D.D.S.
Emily J. Baran, D.D.S.

OFFICE FINANCIAL INFORMATION

In an effort to keep dental costs down while maintaining a high level of professional care, we have established the following payment options.

1. Prepayment or payment at the time of service using cash or check.
2. Use of the following credit cards: *VISA*®, MASTERCARD® and DISCOVER®
3. Care Credit.
4. All major treatment involving a laboratory procedure or orthodontics will require a down payment.

INSURANCE

If your family has dental insurance, we will submit your claims on your behalf with assignment of benefits to our office.

If operative procedures are needed a pre-authorization of benefits will be submitted upon request.

If your plan has a deductible and co-payment, it is collected at the time of service.

Although your insurance company may cover your dental treatment at our office you are responsible for payment of any outstanding balance.

Professional care is provided to our patients not to an insurance company. Thus, the insurance company is responsible to the insured and the insured is responsible to the doctor.

We will file your claims on your behalf however, you are responsible for knowing and understanding what your policy will and will not cover.

If an account is sent to a collection agency for nonpayment, no further appointments will be scheduled.

APPOINTMENTS

We require twenty-four (24) hours notice if you must change a scheduled dental appointment. Less than 24 hours notice, or not showing for an appointment, is counterproductive for both the patient and our office. A fee of $30.00 or more may be assesed for each missed appointment.

I have read, fully understand and agree with the financial/appointment policies of this practice.

Responsible Party ______________________ Date ______________

395 N West Street • Suite A • Westerville, Ohio 43082-1400 • 614-898-9994