Geneseo Orthodontics & Pediatric Dentistry

70 Main St Geneseo, NY 14454

585-245-0050

info@geneseosmiles.com

Cell Phone: _____ Email: _____

How did you hear about us: _____

Patient's Name: _____ Person Responsible for account:

Nickname: _____ Male { } Female { } Name: _____

DOB: ___/___/___ Age: _____ Address (if different): _____

Address: _____ _____

_____ _____

Parents Marital Status (circle): Single, Married, Widowed, Divorced, Separated

Mother/Father's Name:_____ DOB: _____

Cell Phone: _____ Other Phone: _____

SSN: _____ Employer: _____

Mother/Father's Name: _____ DOB: _____

Cell Phone: _____ Other Phone: _____

SSN: _____ Employer: _____

Dental Insurance:

Insurance Carrier: _____ Insurance Company: _____

Subscriber Id # _____ Insurance Phone: _____

Financial Policy

Geneseo Orthodontics and Pediatric Dentistry

70 Main Street Geneseo, NY 14454
585-245-0050

Thank you for choosing Geneseo Orthodontics and Pediatric Dentistry! Our primary goal and responsibility is to help our patients obtain high quality dental care in a relaxed, supportive, and fun environment. We present this Financial Policy to prevent misunderstandings and direct our time and energy towards this goal. Please read carefully and sign prior to treatment.

- Payment for all services provided by the practice is due in full at the time the services are rendered unless other arrangements have been made prior to your appointment.
- If you have private insurance, we will be happy to file for your visit. Your dental insurance is a contract between your employer and the insurance company. The percentage covered for each procedure is determined by how much your employer has paid for coverage. We will be happy to assist you in estimating your portion of the cost of treatment, but we would strongly recommend you become familiar with your insurance benefits ahead of time.
- We will collect your Estimated Patient Portion not covered by your insurance, including your deductible and percentage not covered.
- Some insurance carriers will not reimburse our office directly. In such instances, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.
- For your convenience, we accept cash, checks, and most major credit cards. Any returned checks will incur a $30 processing fee.
- A rebilling charge of $5 per month on the unpaid balance will be charged after 30 days. For accounts outstanding more than 60 days from treatment date, the $5 per month fee plus 2% interest per month will be charged.
- The parent or legal guardian who accompanies the minor at the appointment is responsible for payment of the Estimated Patient Portion.
- In the even that any outstanding balance must be referred to a collection agency or attorney for recovery, you will be fully responsible for all collection agency fees and attorney fees.
- If there are repeated broken appointments or canceled appointments with less than 24 hour notice, there may be a $35 charge applied to your account.

Please sign and date below to indicate that you have read and fully understand Geneseo Orthodontics and Pediatric Dentistry's Financial Policy.

Patient Name: _____

Signature: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient(s) Name(s): _____ DOB: _____

Please Read the Following Carefully:

Purpose of Consent: By singing this form, you will consent to our use and disclosure of your/your child's protected health information to carry out treatment, payment activities and healthcare operations.

[ ] I agree to receive appointment reminders by text message or email. I am aware that I can opt out an anytime.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, healthcare operations, uses and disclosures we may make about your child's protected health information, and other important matters about your child's protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's protected health information that we maintain.

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. You may obtain a copy of our Notice of Privacy Practices at any time, including any revisions of our Notice, by contacting:

Geneseo Orthodontics and Pediatric Dentistry PLLC- 70 Main Street Geneseo, NY 14454

Phone: 585-245-0050. Email info@geneseosmiles.com

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. Please understand that revocation of this consent will not affect any action we took in reliance of the consent before we received your revocation, and that we may decline to treat your child or continue treating your child if you revoke this consent.

Signature:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing the Consent form, I am giving my consent to your use and disclosure of my/my child's protected health information to carry out treatment, payment activities, and healthcare operations.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Patient/Parent/Guardian Printed Name: _____ **Relationship to Patient** _____

Please list anyone (other parent, family members) to whom we can speak regarding the patient's care:

1.) _____ Relationship: _____

2.) _____ Relationship: _____

Geneseo
Orthodontics &
Pediatric Dentistry

Use of Photos and/or Video

Welcome to Geneseo Orthodontics & Pediatric Dentistry! We pride ourselves on being a fun, friendly and dynamic office. We frequently have contests and promotions that run in the office and on social media sites such as Facebook. This document outlines how you wish for us to handle the use of your name, photos and videos taken of you during your time as a patient with us.
As you'll see below, there are a number of options for you to choose from. Please review this carefully and initial the areas that you feel comfortable giving us permission.
Thank you.

I consent to allow Geneseo Orthodontics & Pediatric Dentistry to use:

Intra-oral photos of my teeth only:	Yes/No
Photos of my face:	Yes/No
My name:	Yes/No
Videos of me:	Yes/No

Photos to be used for:

Research, training, lectures or case studies:	Yes/No
Before and after photos:	Yes/No
Promotions or marking-website, Facebook, brochures:	Yes/No

Only as indicated above, I authorize use of my images and/or name without compensation to me. I hereby release the photographer and orthodontist at Geneseo Orthodontics & Pediatric Dentistry from all claims and liability to said photographs.

Patient/Guardian Signature: _____Date: _____

Patient's Name _____ Date of Birth ____ / ____ /_____

Child's Dental History

	YES	NO
Do you desire complete dental care?	☐	☐
Are there any dental concerns?	☐	☐
Any unhappy dental experiences?	☐	☐
Any unusual speech habits?	☐	☐
Any mouth habits? If yes, circle all that apply: (nursing bottle, pacifier, snoring, grinding, thumb/finger sucking, mouth breather)	☐	☐
Does child brush daily?	☐	☐
Does child floss?	☐	☐
Is there parental aid or supervision when child brushes and/or flosses?	☐	☐
Do you have fluoridated water?	☐	☐
Is fluoride taken is any other form?	☐	☐
Has there been pain/problems in the jaw? (TMJ)	☐	☐

Previous Dentist _____

Date and reason for last visit _____

_____

Date of last dental x-rays _____

May we take any necessary x-rays? _____

Describe child's attitude toward dentistry _____

_____

_____

Dental Summary. Please use this space for any further information.

_____

_____

_____

_____

_____

_____

Child's Medical History

Physician _____ Physician's Phone #_____

Address_____

Date of last physical exam _____ Results _____

	YES	NO
Is child under care of a physician now?	☐	☐
Is child receiving any medication or drugs?	☐	☐
Does your child have a heart murmur?	☐	☐
Is there excessive bleeding when cut?	☐	☐
Has child ever been hospitalized?	☐	☐
Has child ever had surgery?	☐	☐
Is there an allergy to penicillin?	☐	☐
Is there an allergy to other drugs?	☐	☐
Other allergies? (such as food, pollen, animals)	☐	☐
Any handicaps/disabilities?	☐	☐
Has there been onset of menses?	☐	☐

If yes, please explain.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please give us date of 1st menstruation

_____

Had your child had any history of or difficulty with any of the following?

	YES	NO		YES	NO		YES	NO
AIDS/HIV	☐	☐	Convulsions/Epilepsy	☐	☐	Mastoid	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Measles	☐	☐
Asthma	☐	☐	Fainting	☐	☐	Mononucleosis	☐	☐
Bleeding Problem	☐	☐	Hearing	☐	☐	Mumps	☐	☐
Cancer	☐	☐	Heart/Heart Defects/Murmurs	☐	☐	Rheumatic Fever	☐	☐
Cerebral Palsy	☐	☐	Hemophilia	☐	☐	Thyroid	☐	☐
Chicken Pox	☐	☐	Hepatitis	☐	☐	Tuberculosis	☐	☐
Chronic Sinus	☐	☐	Kidney/Liver	☐	☐	Venereal Disease	☐	☐

If yes to any of the above, please give a short explanation.

_____

_____

_____

_____

Please describe any current medical treatment, including drugs, pending surgery, recent surgery, or any other information of which we should be aware.

_____

_____

_____

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need and to use local anesthetics and other drugs deemed necessary or helpful in completing treatment.

Signature _____ Date _____

Relation to Child _____

Dentist's Signature _____ Date _____