CM Vera DMD, MPH
MWPanagiotu DDS
41 Lancaster Street
Worcester, MA01609
508-754-9825

Patient Information **Date**_____

_____
Last Name First Name Middle Initial Gender Birthdate

_____
Social Security #: Home Address City/Town, Zip

_____
Cell Phone Home Phone Work Phone/ Mother Work Phone/Father

_____
Email Address Preferred Contact Method

_____
Father's Name Birthdate SSN # Occupation/Employer

_____
Mother's Name Birthdate SSN# Occupation/Employer

_____
Parents' Information Single Separated Married Divorced Widowed

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Custody Information:

1. Shared Custody: State name of each parent or guardian _____ and _____
   ** ***Written authorization by the non-attending parent and/or guardian must be received by Worcester Kids' Dentist <u>prior</u> to commencement of any and all dental treatment***.

2. Sole Custody: State name _____

   State relationship to child: _____
   Copy of the most recent Court Order must be provided to Worcester Kids' Dentist prior to commencement of any and all dental treatment.

_____
Previous or Family Dentist Address: Telephone

_____
Child's Physician Telephone Urgent medical conditions/alerts

_____
How did you hear about us? Website Referral/by whom

_____
Date of Last Cleaning: Last date of most recent x-rays

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FINANCIAL POLICY

In effort to avoid any misunderstanding, we would like to review our Financial Policybefore you or your child begins dental treatment in our office.

Initial Below:

- ✓ _____ Please be aware that federal law makes the parent who brings a child and authorizes the medical/dental treatment responsible for payment of fees, regardless of other contracts or agreements.
- ✓ _____ Payment is expected for treatment rendered at the time of service. We accept MC/Visa/Discover/Debit, checks and cash. For extensive services, we offer payment plans.
- ✓ _____ If you are in need of an extended finance option, we also work with Care Credit, which offers 3,6,12 or 18 month "same as cash" or longer terms, with an interest bearing revolving charge designed to meet your treatment plan needs, on approved credit. Please see our billing manager regarding Care Credit.
- ✓ _____ A return check fee of $15 will be charged for all returned checks.
- ✓ _____ A specific amount of time is reserved especially for you or your child, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice.
- ✓ _____ After the second "no call / no show" broken appointment, there will be a charge of $30.
- ✓ _____ I agree to pay a $30 service fee in the event my account goes to collections.
- ✓ _____ In the case of divorce, the parent bringing the child to the office will be deemed financially responsible.
- ✓ _____ We will send a pre-estimate to your insurance company, if requested.

FINANCIAL POLICY FOR PATIENTS WITHDENTAL INSURANCE

You will need to supply us with the subscriber information (name, date of birth, SSN#, employer, ID# and/or group #), as well as the name and address of your insurance company. Any specific questions you may have relative to your insurance coverage should be made, by you, directly to your insurance company. It is the patient's responsibility to confirm that Worcester Kids' Dentist is listed as a provider on your specific plan.

As a courtesy to our patients, we will gladly submit an insurance claim to your insurance company. We will collect your estimated co-payment and deductible from you at the time of service, and your insurance company will pay our office directly. We make every effort to determine benefits when you or your child receive treatment, but consider your co-payment to be an **estimate** until we receive the actual payment from your insurance company.

Please bear in mind that any information that we provide relative to your insurance benefits is just our best **estimate,** and is not a guarantee of the payment that will be received.

Name:_____Signed:_____

Date:_____

We always welcome comments from you, whether they are positive or negative in nature. Without your critique, we have no way of knowing how to improve our practice. We want to be responsive to your needs and your feedback is essential to our understanding those needs!

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Insurance Information

Primary Dental Insurance Company

Name _____
Name of Insured _____
SS# _____
Subscriber DOB_____
City, State _____
Employer of insured_____

Secondary Dental Insurance Company

Name _____
Name of Insured _____
SS# _____
Subscriber DOB _____
City, State _____
Employer of insured _____

_____ Person Responsible for the Account

_____ Billing Address

I authorize my insurance company(ies) to pay benefits directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I will be responsible for all copayment, deductible and rejected charges.

_____ Signature

_____ Date

_____

Consent for Dental Treatment

I request and authorize Dr Vera and/or Dr Panagiotu and their staff to examine, clean and provide my child with routine dental treatment which may include x-rays, fillings, crowns, extractions and local anesthesia. 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. Dr Vera and Dr Panagiotu will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I understand that I will be responsible for any charges incurred on this child for dental treatment.

_____ Signature Legal Guardian _____ Print Name _____ Date

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Worcester, MA 01609
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

41 Lancaster Street
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(508)754-9825
Fax: (508) 754-9898

Patient Name: _____ Patient Name: _____
Date of Birth: _____ Date of Birth: _____

Patient Name: _____ Patient Name: _____
Date of Birth: _____ Date of Birth: _____

Please note: Only a legal guardian or parent with custody can consent to procedures such as nitrous oxide and extractions. Please consider that when your child is coming in for a procedure that requires written consent.

I,_____, give my permission for the following individuals to accompany my child(ren) to his/her dental appointment in the event I am unable to be present:

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Name Relationship to patient

_____ _____
Signature of parent/guardian Date