Aesthetic Edge, The Dental Practice Of Mankirat Gill DDS Professional Corporation

Patient Information for a Minor Patient

Today's date: ____________________

Patient name (first, MI, last): ____________________

Patient's nickname: ____________________

Patient's primary residency: ☐ Both parents ☐ Mother ☐ Father ☐ Stepparent ☐ Shared custody ☐ Guardian

Address (street, city, state, ZIP): ____________________

Home phone: ____________________ **Gender:** ☐ Male ☐ Female

Date of birth: ____________________ **Age:** ____________________

School: ____________________ **Hobbies/sports:** ____________________

Names and ages of other children in your family: ____________________

Parent / Guardian Information

Name of responsible party (first, MI, last): ____________________

Date of birth: ____________________ **Relationship to patient:** ____________________

Address (if different from patient), (street, city, state, ZIP): ____________________

Home phone: ____________________ **Work phone:** ____________________

Mobile phone: ____________________ **E-mail:** ____________________

By providing your e-mail address you agree to receive (check one or both): ☐ Appointment reminders ☐ Practice newsletter

Employer: ____________________ **Occupation:** ____________________ **Work phone:** ____________________

Work address (street, city, state, ZIP): ____________________

Name of financially responsible party, (if different from above), (first, MI, last): ____________________

Is financially responsible party the same as legal guardian? ☐ Yes ☐ No

Date of birth: ____________________ **Relationship to patient** (mother, father or other): ____________________

Address (if different from patient), (street, city, state, ZIP): ____________________

Employer: ____________________ **Occupation:** ____________________ **Work phone:** ____________________

Work address (street, city, state, ZIP): ____________________

Dental Benefit Plan Information

Primary dental plan name: ____________________

Address (street, city, state, ZIP): ____________________

Name of insured: ____________________ **Date of birth:** ____________________

ID number: ____________________ **Policy number:** ____________________

Patient relationship to insured: ____________________

Secondary dental plan name: ____________________

Address (street, city, state, ZIP): ____________________

Name of insured: ____________________ **Date of birth:** ____________________

ID number: ____________________ **Policy number:** ____________________

Patient relationship to insured: ____________________

Medical Plan Information

Plan name: ____________________

Address (street, city, state, ZIP): ____________________

Name of insured: ____________________ **Date of birth:** ____________________

ID number: ____________________ **Policy number:** ____________________

Patient relationship to insured: ____________________

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Authorizations for Responsible Party Form

We are committed to providing you and your child with the best possible care. Toward this goal, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment:

____.

Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help the parents and guardians of our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this and you will be responsible for the difference.

If we are not a contracted provider with your dental benefit plan, it is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $______ or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $______ or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that my child may need and have consented to during diagnosis and treatment. (initial) ______

I have read the above and agree to the financial and scheduling terms. (initial) ______

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) (initial) ______

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. (initial) ______

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. (initial) ______

Signature of responsible party:____ Date: ________________________

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