Great Grins for KIDS

kids' dentistry and braces

13908 SE Stark Street, Suite C Portland, Oregon 97233 *(503) 254-5535*
911 Main Street, Suite 140 Oregon City, Oregon 97045 *(503) 656-0631*
www.greatgrins.NET

How should we communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Your name: _____ Today's Date: _____
Complete all that apply:
Contact me by US Mail at this address: _____
_____

Contact me by email at this address: _____

Optional Phone and Text Comunications:
(You do not need to sign this form to receive care in our dental office.)

Phone number that you prefer: _____
Other phone number that we can call: _____

My initial here _____ means I consent to the following:
The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

_____ Call me _____ Text me

Signature: _____ Date: _____

Please call our office at (503) 656-0631 right away if you get a new telephone number!

For Office Use Only:

_____ Consent revoked on date _____. Staff Initial _____
_____ Possible reassigned (bad) number. date _____. Staff Initial _____
_____ Confirmed accurate number. date _____. Staff Initial _____
date _____. Staff Initial _____
date _____. Staff Initial _____
date _____. Staff Initial _____

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FINANCIAL GUIDELINES

Our primary responsibility is to help our patients experience good dental health and we wish to spend our time and energy toward that end. To avoid misunderstandings, we would like you to know about our financial guidelines and office routines.

Information about dental insurance:

Please understand that your dental insurance benefit program is a contract between you, your employer, and your insurance carrier. **We are not a party to that contract**. You (not your insurance carrier) are ultimately responsible for payment.

Remember that "Covered" dental treatment is negotiated with the employer so some necessary dental treatment may **not** be covered by your insurance carrier. Insurance companies often make up their own Maximum fee that they pay a percentage of. Usually, they will **not** share this information with us, so we have to make estimates that may be incorrect.

If you would like us to bill your insurance, we need accurate personal and insurance information. You may be asked to provide your social security number and copies of your driver's license and insurance card.

- We will diagnose dental problems as accurately as possible; but changes may occur after treatment is started.
- Based on our diagnosis, we will estimate the total cost prior to performing treatment.
- If you have insurance, we will work very hard to calculate the **expected** insurance benefit and your co-payment.
- As a courtesy to you, we will bill your insurance for you after treatment is completed.
- After insurance pays, we will notify you of any difference between the actual and estimated insurance payment.
- We will promptly credit you any over-payment or ask you to promptly pay for any underpayment.
- To make treatment more affordable, we offer the following financial options:
    - Receiving a 10% non-billing discount (7% if by credit card).
    - Financing for up to five years through Care Credit.
    - Asking the doctor to review the treatment alternatives again.
    - Spreading treatment appointments to fit your financial schedule.
    - Prepaying through a "lay-away" type payment plan.
    - Using automatic debit/credit card billing.

Office routines you should remember:

1. We accept cash, bank debit cards, credit cards, and Care Credit. We are unable to accept checks until you have become part of our Continuing Care family.
2. Accounts unpaid for over 60 days may accrue interest at 18% per year, or 1.5% per month. If your check is returned to us for Non Sufficient Funds, you will be charged a fee of $25.
3. We must use the doctor's time efficiently and help children who need our care. **We request 48 hours notice to cancel or reschedule an appointment.**

I have read and understand the above._____ Date: _____

I am legally and financially responsible for the child: _____

Mark Mutschler, DDS, MS is an Orthodontist & Board Certified Pediatric Dentist
Fariba Mutschler, DDS is a family dentist, limiting practice to children

HEALTH HISTORY					
	PATIENTS LAST NAME	FIRST NAME	INITIAL	PREFERRED NAME	birth date

Medical history

Circle all medical conditions your child has: NONE or

speech problems, vision problems, hearing loss, diabetes, epilepsy, cerebral palsy, developmental delay,

asthma, heart problems, kidney problems, liver problems, serious infections, congenital birth defects.

Does your child have any other health problems? If so, please describe. YES NO

Is your child being treated by a physician for any health problem? YES NO

Who is your physician? Dr. _____ Phone _____

Does your child take any herbs, diet supplements, or medications? YES NO

If so, which ones?

Is your child allergic to any medications that you know of? If so, which ones? YES NO

Is your child allergic or sensitive to any dental materials, metals, or latex? If so, which ones? YES NO

Has your child had any serious illnesses or surgeries? If so, when and for what? YES NO

Is surgery or medical treatment expected in the future? If so, for what? YES NO

Does your child have a heart or other condition that requires antibiotic pre-medication? YES NO

Does your child have an abnormally long bleeding time? YES NO

Does your child have any learning, psychological, or behavioral problems? If so, please describe. YES NO

Has your child tested positive for: tuberculosis, hepatitis, or HIV? YES NO

Dental history

What is your chief dental concern, ie. what we should do first?

Does your child presently have any pain or other concerns? Please describe. YES NO

Do you or your child have any orthodontic questions or concerns? YES NO

How does your child receive Fluoride? None, In the water, Pills, Drops, Mouthwash, Toothpaste

Does an adult floss your child's teeth at least once each day? YES NO

Does an adult brush your child's teeth at least once each day? YES NO

Does your child have any oral habits such as thumb sucking, pacificer use, etc.? YES NO

Has your child had any injuries to their teeth? If so, please describe. YES NO

Is this your child's first visit to a dentist? If not, when was their last visit? YES NO

Have x-rays been taken before? If so, when? YES NO

Were any dental problems found? YES NO

Has your child received: sealants, fillings, extractions, or appliances? (Circle any that apply) YES NO

Has your child had a hard time with dental treatment in the past? If so, please describe. YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT/GUARDIAN SIGNATURE

PARENT/GUARDIAN PRINT NAME DATE

WRITE ADDITIONAL INFORMATION IN THIS BOX:

reviewing dr. initials:

MED ALERT:

HEALTH HISTORY

PATIENT'S LAST NAME	PATIENT'S FIRST NAME	INITIAL	PREFERRED NAME	BIRTH DATE	GENDER

WHOM MAY WE THANK FOR REFERRING YOU?

OTHER FAMILY MEMBER IN THIS PRACTICE?

PARENT NAME:

MARITAL STATUS

HOME ADDRESS

CITY STATE ZIP

MAILING ADDRESS

HOME PHONE WORK PHONE

CELL PHONE E-MAIL

EMPLOYER

BUSINESS ADDRESS

PRESENT POSITION HOW LONG?

DRIVER LICENSE NUMBER

SOCIAL SECURITY NUMBER BIRTHDATE

OTHER PARENT NAME:

MARITAL STATUS

HOME ADDRESS

CITY STATE ZIP

MAILING ADDRESS

HOME PHONE WORK PHONE

CELL PHONE E-MAIL

EMPLOYER

BUSINESS ADDRESS

PRESENT POSITION HOW LONG?

DRIVER LICENSE NUMBER

SOCIAL SECURITY NUMBER BIRTHDATE

DENTAL INSURANCE 1ST COVERAGE

EMPLOYEE

EMPLOYEE DATE OF BIRTH

SOCIAL SECURITY #

EMPLOYER

INSURANCE COMPANY

ADDRESS

PHONE

POLICY #

GROUP OR LOCAL #

DENTAL INSURANCE 2ND COVERAGE

EMPLOYEE

EMPLOYEE DATE OF BIRTH

SOCIAL SECURITY #

EMPLOYER

INSURANCE COMPANY

ADDRESS

PHONE

POLICY#

GROUP OR LOCAL #

EMERGENCY CONTACT (someone not living with you)

Name

Phone

RELEASE:

I attest to the accuracy of the information on this page.

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my child's healthcare, advice, and treatment provided:
1. to any health care provider and 2. for the purpose of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits directly to the dentist, rather than payable to me and I pay the dentist.

I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services.

By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment for all dental services not paid for (either in whole or in part) by my dental care payor.

I agree to be held accountable for any late fees, missed appointment charges, finance charges, or legal costs that I may incur.

I understand that I am financially responsible for payments in full of all accounts.

PARENT/GUARDIAN SIGNATURE		DATE