WELCOME!

Our *Mission* is to provide specialized and comprehensive care for infants, children, adolescents, and patients with special health care needs in a friendly, safe and state-of-the-art environment with a focus on prevention and education for families. We want your child and you to leave our practice with a positive attitude toward dental care, in order to lay the foundation for a lifetime of exceptional oral health.

Included in this packet is information regarding office policies, offered services, and patient information forms. We ask that you please fill each form out to the best of your knowledge and bring them with you at your child's first appointment. If at any time you have questions please give us a call so that we may assist you.

The single most effective way to maintain the best oral health is by stressing prevention through regular checkups and proper nutrition. Cavities are preventable, but there is more to dental health than monitoring for cavities. We continue to research the latest information regarding not only dental, but overall health in order to provide the most up to date treatment, and recommendations.

It is our goal to help *you* and *your* child develop a positive attitude toward dental health. The Minster Dental TEAM is here to help and we look forward to serving you!

Dr. Philip and Staff

Why we allow Parents in the Room

Let's face it; we all want our children to have a positive experience at the dentist. However, for those experienced in life, there are good days, and bad days. Kids can be unpredictable and all the preparation in the world can have no affect for a child that has made up their mind that they do not want to be at the dentist. If there is one thing I would like for you to remember it is this. Whether your child has a fear or phobia, it is our job to help your child with your direction. Only *you*, as the parent can create the expectation with your child that we are here to **help** them and that in order for us to help them, they must in turn behave appropriately. It is never our job to force a child into treatment. We can however **coach** them through it if they are willing. For in the end, the goal we must strive for is helping your child understand the importance of good oral health, and give them a foundation to build on.

For consultation appointments we allow **both** parents in the room, however for restorative appointments, we only allow **one** parent back in the room with the child during treatment. Children behave better during stressful times with one parent in the room. For special circumstances we will permit two but this is at the discretion of the doctor. **The parent with whom the child will behave the best is who should accompany the child**. This does not always mean the parent whom the child will more likely agree with, but the parent whom the child will respond to if due to defiant behavior the child does not want to cooperate.

This is why we allow parents in the room. You are their constant, their source of assurance and stability. To bring any negative emotions, or past experiences into your child's encounter can negatively affect the outcome. **Your support** for your child during the appointment is both helpful and encouraged. We want you to feel comfortable and confident that your child is receiving the best care we can provide.

Thank You for trusting us with your child's dental health!

APPOINTMENT POLICY

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call the office **at least 24 hours** in advance so that we may give that time to another patient.

- Our Pediatric Office Hours are 8-5 MTW, and 8-3 on Thursdays.
- All restorative (fillings, extractions, etc.) procedures for young children are scheduled in the morning. Children are more prepared and do better in the morning for these types of procedures.
- We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.
- Please plan to arrive 10 minutes or more before your scheduled appointment. **This will allow time for parking** and to complete any additional paperwork so we may see your child on time.
- If you arrive late for your appointment, you may be asked to reschedule for the next available appointment time.
- Again, please call at least 24 hours in advance if a cancellation is unavoidable so that we may utilize our day most efficiently for all our patients.
- Due to scheduling restrictions within our hygiene department at this time, we are only able to schedule one recare/cleaning appointment at a time. We will NOT be able to schedule multiple advance appointments (i.e. two or three appointments for the same patient). This will allow our hygienists to continue to deliver the high quality service our patients have valued in the past. Your attention to this matter is greatly appreciated.
- Broken or missed appointments affect many people. If two (2) broken/missed appointments occur or two (2) cancellations without 24-hour notice, our office reserves the right

to NOT schedule any subsequent appointments and/or charge a $50.00 broken appointment fee.

- *A parent or legal guardian (with official documentation) must be present during all appointments that the child patient is in the office.*

CANCELLATION POLICY

MINSTER DENTAL CARE is pleased to be your dental care provider and hope we can always help you maintain good dental health. Due to this commitment to your health, we maintain a high priority on the time you reserve with us for treatment. We realize situations do occur which makes it necessary to reschedule. **We just ask that you give us 24 hour notice** so that we may make the time available to another patient. An efficient schedule is necessary in controlling the rising costs of dental services, and we strive to provide a fair service for a fair fee. When a reserved block of time is ignored, it hurts the ability of our office to provide service, and hurts other patients who need same-day care or urgent visits, and are obliged to wait longer than necessary.

We reserve the right to charge a fee for not canceling or rescheduling an appointment **24 hours prior to the scheduled appointment date and time**. This fee will need to be paid before future blocks of time may be reserved with MDC. We realize emergency situations do occur, and this will be taken into consideration.

If oral sedation is required for a pediatric restorative appointment, this charge must be paid when scheduling this appointment. This **fee** will be **forfeited** should the appointment **be missed without notice**, or not canceled before close of business the prior day.

If at any time you have questions, please feel free to ask our staff call our office. We are here to help in any way we can.

Thank you for trusting us with your child's dental health!

New Patient Questionnaire

Please take time to fill out this supplement. The information provided will help us better serve you and your child's dental needs. Thanks you!

Name: _____
Birthdate: _____

Dental History
Previous Dentist _____
Has your child been previously treated for dental decay or any dental disease? Y / N
If yes, please explain

Has your child ever been sedated or "put to sleep" for treatment? Y / N

Family Caries History
Does either parent have a history of dental cavities? Y / N
Does your child have siblings with a history of dental cavities? Y / N

Prenatal/Natal History
Did the mother have any problems during pregnancy or delivery? Y / N
Did the Mother take any medications during pregnancy? Y / N
Please specify

Was the child premature? Y / N
What medications (if any) did the child take during infancy?

Oral Habits
Does/did your child use a pacifier? Y / N
Does/did your child suck a thumb or finger? Y / N
Does/did your child grind his/her teeth? Y / N
Does/did your child exhibit any other oral habits? Y / N

Diet
Is/was your child breast or bottle fed? Y/ N
Does/did your child sleep with a bottle? Y / N

What is/was fed from the bottle? Formula / Milk / Juice / Water
Age your child was weaned?
Does your child drink pop? Y / N How often?
Does your child drink juice? Y / N How often?
What does your child eat for a snack?
How frequently does your child snack?
Does your child take gummy vitamins? Y / N If yes, how frequent and time of day?
Does your child eat fruit snacks? Y / N How frequent?

Oral Hygiene
Who brushes your child's teeth? Child / Parent / Parent Only
When are the teeth brushed?
Are the teeth flossed? Yes by: Parent Child No

Trauma
Has there been previous injury to your child's teeth or gums?
Is a mouthguard worn for sports?
Is a bicycle/skating helmet worn?

Social
How many children do you have at home and what are their ages?

What activities, shows, toys, etc. does your child like?

What is something special you would like us to know about your child?

MINSTER DENTAL CARE

PATIENT INFORMATION (PLEASE PRINT) ***CONFIDENTIAL***

_____ Male / Female _____
First Middle Initial Last Birthdate

_____ _____
Mailing Address City, State and Zip Code

_____/_____ _____/_____ _____
Home Phone Cell Phone E-mail address (for office communication)

Patient is: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

_____ _____/_____
Patient's Employer Work Phone- if can be contacted there
Is there dental coverage through this employer? ☐ YES ☐ NO **If YES - Please complete insurance information on back**

_____ _____ _____/_____ Current patient ☐ YES ☐ NO
Spouse's Name Employer Work Phone- if can be contacted there
Is there dental coverage through this employer? ☐ YES ☐ NO **If YES - Please complete insurance information on back**

****

PARENT INFORMATION (for minor children)

_____ _____
Mother's Name Father's Name
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Married ☐ Divorced ☐ Separated

_____ _____
Mailing Address (if different than patient) Mailing Address (if different than patient)

_____ _____
City, State and Zip Code City, State and Zip Code

_____/_____ _____/_____ _____/_____ _____/_____
Contact Phone Number Work Phone Contact Phone Number Work Phone

_____ _____ _____ _____
Social Security Number Date of Birth Social Security Number Date of Birth

_____ ☐ YES ☐ NO _____ ☐ YES ☐ NO
Employer **Dental** Insurance Employer **Dental** Insurance

****

I understand that I am financially responsible for all charges incurred and have seen the office policy form. I understand a minimum of $2.00 per month or 2% of my total balance finance charge will be assessed on all unpaid balances over 30 days. I authorize ***MINSTER DENTAL CARE*** permission to use and disclose health/personal information about me (or said minor) for treatment, payment and healthcare operations (as stated in 2013 HIPAA). If patient is a minor, authorization is hereby granted for ***MINSTER DENTAL CARE*** to provide dental care for said minor.

Signature of Patient (over 18) OR **Parent/Guardian** (If Minor) X_____

Relationship to Patient _____ Date _____

****

NEW PATIENTS

Reason for today's visit _____
Former Dentist _____ City/State _____
Reason for Leaving _____
Last dental visit _____ Last dental cleaning _____ Last dental x-rays _____

If minor, has child ever been in the hospital? ☐ Yes ☐ No If yes, why? _____
If minor, has child ever been to the Emergency room? ☐ Yes ☐ No If yes, Why? _____
If minor, has child had any unfavorable experiences in a dental / medical office? ☐ Yes ☐ No
Any significant concerns regarding this child's medical / dental history? ☐ Yes ☐ No

IF NEW PATIENT --- PLEASE COMPLETE:

Bad breath	□ Yes	□ No	Food collect between teeth	□ Yes	□ No	Piercings – tongue&/or lip	□ Yes	□ No
Bleeding gums	□ Yes	□ No	Grinding teeth	□ Yes	□ No	Sensitivity to cold	□ Yes	□ No
Blisters on lips or mouth	□ Yes	□ No	Gums swollen or tender	□ Yes	□ No	Sensitivity to heat	□ Yes	□ No
Burning sensation on tongue	□ Yes	□ No	Jaw Pain or tiredness	□ Yes	□ No	Sensitivity to sweets	□ Yes	□ No
Chew on one side of mouth	□ Yes	□ No	Lip or cheek biting	□ Yes	□ No	Sensitivity when biting	□ Yes	□ No
Chew tobacco	□ Yes	□ No	Loose teeth or broken fillings	□ Yes	□ No	Smoking-cigarette/pipe/cigar	□ Yes	□ No
Clicking or popping jaw	□ Yes	□ No	Mouth breathing	□ Yes	□ No	Sores/growths in mouth	□ Yes	□ No
Dry mouth	□ Yes	□ No	Mouth pain, brushing	□ Yes	□ No	Thumb/finger sucking	□ Yes	□ No
Fingernail / lip biting	□ Yes	□ No	Orthodontic treatment	□ Yes	□ No			
Fluoride supplements	□ Yes	□ No	Pacifier	□ Yes	□ No	How often do you floss? _____		
Fluoride rinse	□ Yes	□ No	Pain around ear	□ Yes	□ No	How often do you brush? _____		
Fluoridated water	□ Yes	□ No	Periodontal treatment	□ Yes	□ No			

****

DENTAL INSURANCE INFORMATION – (PLEASE PROVIDE CARD FOR COPYING)

Primary Insurance

_____
Name of Insured

_____ _____
Relationship to patient Insured's birthdate

_____ _____
Employer Social Security Number

_____
Insurance Company

_____
Insurance Company Address

_____
City State Zip Code

Secondary Insurance

_____
Name of Insured

_____ _____
Relationship to patient Insured's birthdate

_____ _____
Employer Social Security Number

_____
Insurance Company

_____
Insurance Company Address

_____
City State Zip Code

Federal Truth in Lending Statement

In the event that your insurance applies services to a deductible, determines a service is not payable due to frequency, is not covered, or is disallowed for any reason the balance will become the responsibility of the patient or responsible party. In the event this occurs you will be billed for the services not covered for any reason, rejected, or applied to the deductible. I understand that if an insurance plan has an adjustment from the provider for services and the amount required by the insurance is either more or less than what was estimated at the time of service by the provider, I may be billed an additional amount after insurance benefits and any adjustments are determined.

I have read and understand that the services provided may be covered in part or in full by my insurance carrier. In the event the insurance does not pay the dentist for covered, non-covered, or services applied to a deductible I am fully responsible for the balance.

Authorization and Release

I authorize and request my insurance company to pay directly to Minster Dental Care otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of patient (or parent/guardian if minor) **Date**

Minster Dental Care Health History

Patient Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank for answering the following.

Are you under a physician's care now?	□ YES □ NO	If yes, why:
Have you ever been hospitalized or had a major operation?	□ YES □ NO	If yes, why:
Have you ever had a serious neck injury?	□ YES □ NO	If yes, why:
Are you taking any medications, pills, or drugs?	□ YES □ NO	If yes, why:
Do you require pre-medication or an antibiotic prior to dental procedures?	□ YES □ NO	If yes, why:
Do you take, or have you taken, Phen-Fen or Redux?	□ YES □ NO	If yes, why:
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	□ YES □ NO	If yes, why:
Are you on a special diet?	□ YES □ NO	If yes, what:
Do you use tobacco?	□ YES □ NO	If yes, what:
Do you use controlled substances?	□ YES □ NO	If yes, why:

Women: Are you…

□ Pregnant or trying to get pregnant? □ Nursing? □ Taking oral contraception?

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic

□ Metal □ Latex □ Sulfa Drugs □ Local Anesthesia

Other: _____

Do you have, or have you had any of the following:

AIDS/HIV	Y / N	Cortisone Medicine	Y / N	Hemophilia	Y / N	Radiation Treatment	Y / N
Alzheimer's Disease	Y / N	Diabetes	Y / N	Hepatitis A	Y / N	Recent Weight Loss	Y / N
Anaphylaxis	Y / N	Drug Addiction	Y / N	Hepatitis B or C	Y / N	Renal Dialysis	Y / N
Anemia	Y / N	Easily Winded	Y / N	Herpes	Y / N	Rheumatic Fever	Y / N
Angina	Y / N	Emphysema	Y / N	High Blood Pressure	Y / N	Rheumatism	Y / N
Arthritis / Gout	Y / N	Epilepsy or Seizures	Y / N	High Cholesterol	Y / N	Scarlet Fever	Y / N
Artificial Heart Valve	Y / N	Excessive Bleeding	Y / N	Hives or Rash	Y / N	Shingles	Y / N
Artificial Joint	Y / N	Excessive Thirst	Y / N	Hypoglycemia	Y / N	Sickle Cell Disease	Y / N
Asthma	Y / N	Fainting / Dizziness	Y / N	Irregular Heartbeat	Y / N	Sinus Trouble	Y / N
Blood Disease	Y / N	Frequent Cough	Y / N	Kidney Problems	Y / N	Spina Bifida	Y / N
Blood Transfusions	Y / N	Frequent Diarrhea	Y / N	Leukemia	Y / N	Stomach/Intestinal Issues	Y / N
Breathing Problems	Y / N	Frequent Headaches	Y / N	Liver Disease	Y / N	Stroke	Y / N
Bruise Easily	Y / N	Genital Herpes	Y / N	Low Blood Pressure	Y / N	Swelling of Limbs	Y / N
Cancer	Y / N	Glaucoma	Y / N	Lung Disease	Y / N	Thyroid Disease	Y / N
Chemotherapy	Y / N	Hay Fever	Y / N	Mitral Valve Prolapse	Y / N	Tonsillitis	Y / N
Chest Pains	Y / N	Heart Attack/Failure	Y / N	Osteoporosis	Y / N	Tuberculosis	Y / N
Cold Sores/Fever Blisters	Y / N	Heart Murmur	Y / N	Pain in Jaw Joints	Y / N	Tumors or Growths	Y / N
Congenital Heart Disorder	Y / N	Heart Pacemaker	Y / N	Parathyroid Disease	Y / N	Ulcers	Y / N
Convulsions	Y / N	Heart Trouble/Disease	Y / N	Psychiatric Care	Y / N	Venereal Disease	Y / N
Yellow/Jaundice	Y / N	Brain Damage	Y / N	Circulatory Problems	Y / N	Parkinson's Disease	Y / N

Have you ever had any serious illness not listed above? If yes, what:

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform Minster Dental Care of any changes in medical status.

SIGNATURE OF PATIENT / PARENT / GUARDIAN: DATE:

Consent for Dental Treatment

I request and authorize Dr. Slonkosky 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 Dr. Slonkosky to diagnose and /or treat my child's dental problem. I will allow photographs to be taken of my child or 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. Dr. Slonkosky 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 will be responsible for any charges incurred on this child for dental treatment.

_____ _____

Signature Date

"Dental Insurance and Our Office"

Minster Dental Care currently participates with ***Superior Dental Care*** and ***Delta Dental (Premier)*** insurance plans. Any traditional dental plan can be billed by Minster Dental Care and any unpaid balance from our fees is then owed by the patient. A copy of your current dental insurance card must be provided (including the insured's name, group number, ID number, mailing address for claims, etc). If you do not have a dental card, a current *completed* dental insurance form is needed.

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients utilizing many different insurance companies and policies. Each company pays an insurance premium and determines the amount of coverage available. Each plan is slightly different in its covered services. We encourage you to become familiar with your policy benefits exclusions, deductibles, required co-payments and frequency limitations. Your policy may have a yearly/lifetime maximum and would include treatment at our facility or any other dental facility. Also, plan benefit periods do not all run from January thru December, and it is the insured's responsibility to know their specific policy terms.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is the patient's responsibility to keep MINSTER DENTAL CARE informed of changes in current insurance information including address and/or phone number and change in ID numbers. This will ensure all insurance claim filing and statements can be kept to a minimum.

The top two misunderstood facts regarding dental insurance are:

Fact 1 – No insurance pays 100% of all procedures.
Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company. There are literally thousands of contracts available for employers to choose from provided by each carrier.

Fact 2 – Benefits are not determined by our office.
Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a profit. You may have noticed that sometimes your dental insurer reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service. This can be very misleading and simply is not accurate. Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

Payment/Financial Policy

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that payment of your bill is considered a part of your child's treatment. Please familiarize yourself with the information that follows. If you have any questions, please feel free to ask one of our business office staff.

- Please be aware that the parent bringing the child to our office is legally responsible for payment of all charges. We cannot send statements to other persons.
- A copy of the current dental insurance card must be provided (including the insured's name, group number, ID number, mailing address for claims, etc). If you do not have a dental card, a current *completed* dental insurance form is needed.
- Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is the patient's responsibility to keep MINSTER DENTAL CARE informed of changes in current insurance information including address and/or phone number and change in ID numbers. This will ensure all insurance claim filing and statements can be kept to a minimum.
- We expect payment of fees not covered by the insurance plan at the time the service is delivered including, but not limited to, deductible, co-pays, and non-covered services. It is expected that you understand that the insurance policy belongs to you and that we have no leverage to obtain payment from your insurance carrier. The insured realizes that the insurance payment for some services, use restricted fee scheduled (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the policy purchased, not our fees or recommended treatment.
- Please understand that financial arrangements are made directly with you. If alternative arrangements need to be made in order for your child to receive treatment do not hesitate to ask what options are available prior to the start of treatment. For the convenience of our patients, the following options are a guide for possible financial arrangements:

    1. **Payment in full** for each appointment as services are rendered. Minster Dental Care requires that all outstanding balances be paid in full within sixty (60) days of the date service or insurance carrier payment, *unless other arrangements have been made in advance. We reserve the right to apply an interest rate of 2% per month from the date of service.* If you have not paid in full or arranged and honored a payment plan within sixty (60) days, we may/will refer your account to a collection agency. They, in turn, will report your past due status to a Credit Reporting Agency. Any fees incurred by Minster Dental Care for Attorney or Court cost will be your responsibility. ***To prevent this,*** contact our office at any time to discuss alternative payment. We understand circumstances can change unexpectedly and are willing to work with you to settle your account.

2. **Dental Insurance**: There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type of plan chosen by you and/or your employer. As such, we have no say in the selection of your insurance company; we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. We will submit a precertification to your insurance after diagnosis to help ensure more accurate insurance benefits for your plan.

3. **Appliances/Orthodontics:** The cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the lab bills when appliances are ordered, not when they are completed. If the appliance is part of orthodontic treatment, a payment plan can be arrange as needed, depending on the length and extent of treatment.

4. **Emergency treatment**: Patient will be billed for treatment rendered, and is asked to pay in full if possible at time services are rendered. Due to the unexpected nature of emergencies, payment plans can be arranged if needed.

5. **Payment Plans**: For orthodontic treatment and special circumstances we can arrange a payment plan. Depending on the extent of treatment and possible lab costs, a down payment may be required at the start of treatment. We do not charge interest or fees for payment plans. The only requirement is that minimum payment be made at the first of each month. If two subsequent payments are missed without notifying Minster Dental Care, we may/will refer your account to a collection agency.

Our courtesy service to you includes:

1. Filing your insurance within 24 hours of your visit and requesting payment of your benefit to our office.
2. Electronic filing of insurance claims when available.
3. Re-filing your original insurance a second time within 60 days of initial filing, if necessary - a charge will be assessed if multiple filings are required.
4. Following the American Dental Association guidelines for coding procedures and filing insurance.

Our expectations of you as owner of the policy:

1. Payment of fees not covered by the insurance plan at the time the service is delivered. (i.e deductible, co-pays, non-covered services)
2. Understand that the insurance policy belongs to you and that we have no leverage to obtain payment from your insurance carrier.
3. Realize that the insurance payment for some services, use restricted fee scheduled (called Usual and Customary Rates) and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the policy purchased, not our fees or recommended treatment.
4. Taking responsibility for payment if the insurance company does not pay our office within 75 days.
5. *Keep our office informed* of any changes in your insurance carrier and/or employment.

I have read the payment policy as written and have had all questions answered to my satisfaction and understand that by signing, I am financially accountable for all charges for my minor child. Thank you in advance for your understanding of our financial policy!

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness Date

MINSTER DENTAL CARE

HIPAA ACKNOWLEDGEMENT
&
PERMISSION TO DISCUSS MEDICAL INFORMATION

PATIENT NAME: ________________________ DATE OF BIRTH ________________

I have received and/or been offered a copy of the Minster Dental Noticy Of Privacy Practices. I authorize the following list of people who may receive my Protected Health Information. I understand that I may revoke this authorization at any time by giving written notification to the office.

NAME ________________ *DATE OF BIRTH* ________________ *PHONE NUMBER* ________________
RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

NAME ________________ *DATE OF BIRTH* ________________ *PHONE NUMBER* ________________
RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

NAME ________________ *DATE OF BIRTH* ________________ *PHONE NUMBER* ________________
RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

NAME ________________ *DATE OF BIRTH* ________________ *PHONE NUMBER* ________________
RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

NAME ________________ *DATE OF BIRTH* ________________ *PHONE NUMBER* ________________
RELATIONSHIP TO PATIENT: □ SPOUSE / □ CHILD / □ PARENT / □ LEGAL GUARDIAN / □ OTHER ______________

________________________________ ________________
SIGNATURE OF PATIENT OR PARENT / LEGAL GUARDIAN *DATE*

Directions to our Office

From the North:

- Take State Route 66 South – you will be coming through the town of New Bremen
- Shortly before you reach our office you will see True Value Hardware store on the right
- You will then turn right off State Route 66 to an access road which runs parallel to 66
- Once off 66 you will turn LEFT on the access road and you will see a strip mall and we are located south of the strip mall on your RIGHT
- Our building is tan stucco with a green metal roof

From the South:

- Take State Route 66 North – you will be come through the town of Minster
- On the North end of town you will pass the McDonalds restaurant on your right
- Continue North on State Route 66 and shortly you will come to the traffic light at the intersection of State Route 66 and 119 West
- Continue through the intersection and in less than ¼ mile you will see our office building on the LEFT
- Our building is tan stucco with a green metal roof
- You will need to drive past the building and then you will make a LEFT turn off State Route 66 to an access road
- Once on access road make a LEFT turn (you are heading south) and follow to our office which is on your RIGHT