Stephen P Girdlestone DDS

PEDIATRIC DENTAL SPECIALIST

infants children teenagers

Pediatric Dental Specialist – Dr. Stephen Girdlestone

Who may we thank for referring you? -_____

Patient information: **Date:_____**

Child's name _____ Initial __ Last Name _____
Nickname _____ Birth date _____ Age ___ M / F
S.S. #_____
Address where child resides _____
_____
Has your child ever been seen by a dentist? ___ Yes ___ No
If yes, Dentist name_____ Last Visit date_____
Were X-rays taken? ____ Yes ____No
If no, would you like just an exam or exam and cleaning today? _____

Mother and / or Guardian's information:
First, Middle initial & last name

Name _____ Married – Single – Divorced – Separated – Widowed (Circle One)
Address _____
_____
Home phone _____ Work number _____ Cell _____
Other phone number (Grandparents / neighbor) _____
SS# _____ Employer _____
Birth Date: _____

Father's information: First, Middle initial & last name

Name: _____ Married – Single – Divorced – Separated – Widowed (Circle One)
Address if different than mothers _____
_____
Home phone _____ Work number _____ Cell _____
Other phone number (Grandparents / neighbor) _____
SS # _____ Employer _____
Birth Date: _____

Dental Insurance information:
Primary INS holder: Mother or Father Ins Co Name _____
Insurance Co. Name _____
Address _____
_____
Phone number _____
ID number as it shows on card _____
Group Number _____

We do not submit secondary insurance forms. We will be glad to provide you with the paperwork needed to file from home. Be sure and save the EOB's that you receive from your primary insurance company.

Signature _____

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FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. ***It is our policy to make definite financial arrangements with you before any treatment starts.*** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment is due at the time of services. We accept cash, checks, Visa and MasterCard.

2. There will be a failed appointment fee of $50 for scheduled appointments. Our conscious sedation failed appointment fee is $100 if you do not give us a two-day notice of being canceled. If by chance the conscious sedation appointment is not completed the full conscious sedation fee is expected to be paid.

3. The office will accept assignment for only the primary insurance coverage only.

4. **Please provide us with your current dental insurance card so we can confirm your identification number and their mailing address. Insurance companies are not all using social security numbers as identification.**

5. If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.

6. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depends on the quality of the plan purchased by your employer, not the fees of the doctor.

7. ***Please note our office does not accept Medicaid or Medicaid Managed Care (i.e. HMOs) and are not able to treat Medicaid recipients. If, after services have been rendered, it is discovered that a patient is covered by Ohio Medicaid or a Medicaid HMO, Ohio Medicaid and any Medicaid HMO, will not be billed for any Medicaid covered service and that patient will be responsible for the fee for those services***.

8. Dr. Girdlestone is considered an "**out of network**" dentist with all insurance companies except Delta Premier.

9. After 90 days, we will inform you of the delinquent account by letter and if no action is taken to clear the account, this office will be required to employ collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees.

10. There will be a $30.00 service charge for all returned checks.

11. The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

AUTHORIZATION I authorize Dr. Girdlestone & staff to release any information concerning my case to my insurance company. I have read & accept the above Financial Policy, understand it & agree to the terms set forth regarding payment.

Signature of Parent or Responsible Party _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of Dr. Girdlestone's Notice of Privacy Practices.

Patient name _____

Guardian Signature _____

Date _____

I _____ give Permission for the following people to bring in my child/children and discuss treatment and finances.

	Name	Address	Relationship	Phone
1.				
2.				
3.				
4.				
5				

If you need to add anyone else to the list, please fax over the information prior to the appointment at (330) 491-8888. Thank you.