MOUNTAINLAND PEDIATRIC DENTISTRY, INC.

JARED D. PEARSON, DDS

Specialist for Infants Children & Special Needs

How would you like to be contacted*(please check one)* Phone ___ Text____ Email___

CHILDS NAME: First_____Last_____ Male Female
Birthdate:_____Age:_____School:_____
Home Address:_____
City, State, Zip Code:_____
Child lives with: (Circle) Father Mother Both Other
Marital Status of Parents: (circle one) Married Single Divorced Separated Widowed
Email address _____

FATHER:_____ Home Phone:_____ Cell Phone: _____
Social Security Number:_____ Birth date:_____
Father's Employer:_____ Work Phone: _____
Home address if different than child's:_____

MOTHER:_____ Home Phone: _____ Cell Phone: _____
Social Security Number:_____ Birth date:_____
Mother's Employer:_____ Work Phone: _____
Home address if different than child's:_____

(If appropriate) Name of Legal Guardian:_____ Phone: _____

PERSON FINANCIALLY RESPONSIBLE:_____
If other than parent please write address: _____
Home Phone:_____ Cell Phone: _____ Work Phone: _____

PAYMENT OPTIONS: Method of payment (please circle one)
Cash, check or credit card at time of service Insurance and co-pay at time of service
Medicaid and co-pay if applicable

PRIMARY DENTAL INSURANCE:
Name:_____
Phone:_____ Policy #_____
Address:_____
_____
Insured Person's Name: _____

SECONDARY DENTAL INSURANCE:
Name:_____
Phone:_____ Policy # _____
Address: _____
_____
Insured Person's Name: _____

HEALTH (Medical) INSURANCE INFO: Name: _____
Address: _____ Phone: _____

REFERRAL INFORMATION:
Whom may we thank for referring you to our office:
Dental Office: (Doctor's name) _____ Yellow Pages: _____
Another Patient: (name) _____ Friend (name) _____
School: _____ Work: _____ Other: _____

DENTAL HISTORY:

Why is your child here today? _____
Is there a specific problem? _____
Is your child currently taking fluoride? _____ How often? _____
Has your child been to the Dentist before? _____ Date: _____
How was your child's experience? _____
Has your child had x-rays taken before? _____ Date: _____
Is your child currently on the bottle? _____ Pacifier? _____ Sippy cup? _____
Nursing? _____ Thumb Sucking? _____ Grinding? _____
Do you currently help your child brush and floss? _____
How often does he/she brush? _____

MEDICAL HISTORY:
Name of Physician: _____
Date of last physical exam: _____ Any findings: _____
Is your child's immunization up to date? _____
Is your child currently taking any medication? _____ If yes, what? _____
Is your child currently under the care of a physician for any reason? _____
If yes, what? _____
If your child allergic to any medications? _____ If yes, what? _____
Has your child ever had a traumatic medical or dental injury? _____
If yes, what? _____ Date: _____
Has your child ever been hospitalized? _____
If yes, for what? _____ Date: _____

DOES YOUR CHILD HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING?
PLEASE CIRCLE ALL THAT APPLY TO YOUR CHILD:

ADHD	Y	Tubes in ears	Y	Radiation treatment	Y
AIDS	Y	Endocrine system	Y	Respiratory Treatment	Y
Allergies	Y	Fainting	Y	Respiratory Problems	Y
Anemia	Y	Hearing/Sight	Y	Rheumatic Fever	Y
Artificial Joints	Y	Heart Murmur	Y	Seizures	Y
Asthma	Y	Heart Condition	Y	Tuberculosis	Y
Blood Disease	Y	Head injury	Y	Downs Syndrome	Y
Blood Transfusion	Y	Frequent Headaches	Y	Vomiting/Diarrhea	Y
If yes date: _____		Kidney Disease	Y	Allergies/Adverse reaction to	
Behavioral/learning		Liver disease	Y	medication? _____	
disorder	Y	Mental Disorder	Y	Any other medical condition	
Breathing/lung		Mental/Physical		not listed? _____	
problems	Y	Development Delay	Y	_____	
Cancer/Tumor	Y	Pregnancy	Y	_____	
Congenital birth		Due Date _____			
defects	Y	Multiple ear infections	Y		

I have read the above and have answered them to the best of my knowledge. I have updated this form as above requested.

Signature _____ Date __ _____

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Cancellation and Failed Appointment Policy

As a patient in our office, it will be your responsibility to keep scheduled appointments. The office will require notification of cancellation at least 24 hours prior to the appointment or earlier if possible. This can be done by calling our office at (801)766-2111.

The office will consider a "failed appointment" at any time a patient has not given the advance notice required above or has failed to arrive within 15 minutes of their appointment time. For every failed appointment **there will be a $25 fee.** When a patient fails three appointments in a 2-year period, the office will no longer schedule appointments for that patient.

I have read and understand the above policy and agree to abide by this policy.

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)

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Patients name: _____
Parent or Guardian name: _____
Relationship to patient: _____

Consent to proceed:

I authorize Dr Jared D Pearson D.D.S. and/or such associates or assistants as he may designate to perform those procedures as may be necessary or advisable to maintain my dental health or the dental health or any minor or other individual for which I have responsibility including arrangement and/or administration of any sedative including but not limited to nitrous oxide, general anesthesia, analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.

Signature _____ Date _____
(Patient, legal guardian or authorized agent of patient)

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FINANCIAL AGREEMENT

To our valued patients:

In order to keep our fees as low as possible we have implemented the following policies.

- I understand that **if the patient does not have dental insurance,** payment in full is expected on the day of service, unless other arrangements have been previously made.
- I understand that if **the patient does have dental insurance,** the responsible party will pay the patient estimated portion, and deductible on the day of service: the insurance will be billed as a courtesy, however, **I am aware, if the insurance does not pay within 60 days payment in full is expected from the responsible party.** Mountainland Pediatric Dentistry bills to over 200 insurance companies. I understand it is my responsibility to know and understand my benefits, and the fee's quoted in our office are only estimates. I am responsible for anything that my insurance does not cover. I understand that every 6 months my child will have a full exam, x-rays, and prophylaxis/fluoride treatment. If my insurance does not cover it that often, it is my responsibility to let the staff know before my child's appointment. I understand that if another dentist has referred my child my insurance may not cover the cost of the exam, or x-rays due to plan limitations, and it is my responsibility to pay.
- All emergency dental services or any dental services performed without previous financial arrangements must be paid for in full at the time of service.
- When scheduling dental surgery a **$100 non-refundable** deposit is required and dental co-pays are due no later than 1 week prior to surgery. If I do not show up for surgery I understand that to reschedule I will have to pre-pay my co-pay in full. If my child has Medicaid I will be required to make a $100.00 deposit that will be refunded to me within a week after surgery.
- When scheduling work with an oral sedation I understand that most insurances **will not** cover this charge. **The sedation fee of $158 is due in full on the date of service.** If I am late for a sedation appointment I understand my appointment will be rescheduled.
- Upon examination the doctor will prepare a treatment plan. The **treatment plan is only an estimate** of the dental care required and should not be construed as a statement of actual charges.
- There will be a **$25 returned check fee** assessed to your account on all returned checks**.** A service charge of 1.5% (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination. In addition, there will be late fees, certified letter fee's, rebilling fee's and finance charges added to all accounts over 90 days late. Credit checks will be obtained with **all** financial arrangement's that are not paid on the date of service. Information given may be used to collect a debt.
- The responsible party agrees to pay all attorney fees and court costs associated with collecting payment for services rendered. Collection fees of approximately 50% are added to the account when it is turned over to the agency.
- I grant my permission for you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.
- I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information.

I have read and understand the above policy and agree to abide by this policy.

_____	_____	_____
Signature of parent or Guardian	**Date**	**Relationship to Patient**