Get Acquainted Questionnaire

Tell Us About Your Child!

Today's Date _____

Child's First Name _____ Child's Last Name _____ Nickname_____

Male or Female Child's Age _____ Child's Date of Birth _____/_____/_____

Residence Address _____City_____ State _____Zip_____

Residence Phone _____ Email Address_____

School_____ Grade _____

Please list any special interest, favorite toys, movies _____

1. Who is Accompanying the Child Today?

Name_____ Relation _____

Do you have legal custody of the child? Yes_____ No_____

Parents Marital Status:
Single____ Married___ Widowed____ Divorced_____ Separated_____

Whom may we thank for referring you?_____

2. Mother's Information
Stepmother_____ Guardian____

Name_____

Date of Birth____/_____/_____

Wk/Cell #_____Home#_____

SS#_____

Present Employer_____

Father's Information
Stepfather_____ Guardian _____

Name_____

Date of Birth____/_____/_____

Wk/ Cell#_____Home#_____

SS# _____

Present Employer _____

3. Person Responsible for the Account

Name_____Relation _____

Billing Address_____City_____State_____Zip _____

Who is responsible for making appointments?

Name _____Wk #_____Home # _____

4. DENTAL Insurance Information

Primary Insurance Company Name:_____Insurance Company Phone #_____

Mailing Address_____City_____ State_____Zip_____

Group #_____ Subscriber ID # (We must have this information to file the claim)_____

Policy Owner's Name_____Policy Owner's Date of Birth____ / _____ / _____

Policy Owner's Employer _____

*** LeBlanc & Associates will only file primary insurance. The parent or guardian is responsible for filing secondary insurance claims. Any co-pays or co-insurance rates must be paid at the time services are rendered.**

HEALTH HISTORY QUESTIONNAIRE

Has your child had previous Anesthesia/Sedation or Surgery? YES NO
If Yes, please list: _____
Complications, please list: _____

Does your child take medications? YES NO
If Yes, please list (include herbals): _____

Does your child have any Allergies to Medications? YES NO If Yes, please list:_____
_____
Any reaction to local anesthetics (i.e. Novocain) or antibiotics? YES NO If Yes, please list:_____
_____

Please answer the following questions to the best of your ability:
HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING: (PLEASE CIRCLE ALL THAT APPLY)
Respiratory: Asthma Sleep apnea Snoring Smoking Seasonal Allergies Recent Cold/Flu Frequent Ear/Tonsil Infections Sinus Tuberculosis Other: _____

Cardiovascular: Murmur Congenital Defect Rheumatic Fever High Blood Pressure Heart Attack Angioplasty/Stents Chest Pain Abnormal Heart Rhythm Other: _____

Liver/Gastrointestinal: Hepatitis Heartburn Ulcers Hernia Bowel/Colon Other: _____

Neurological/Musculoskeletal: Seizures Developmental Disability ADD/ADHD Migraines/Headaches Autism Anxiety Depression Stroke Hearing Impairment Numbness/Tingling Arthritis Back Pain Learning Disability Speech Other: _____

Renal/Endocrine: Diabetes Thyroid Kidney Stones Recent Weight Loss/Gain Other: _____

Hematologic: Cancer/Chemotherapy HIV Bleeding Problems Low Blood Count

Is your child under the care of a physician for any chronic medical problems? YES NO
Please list the name of the supervising Physician responsible for your child's care:
Name: _____ Phone: _____
Address: _____

DENTAL HISTORY

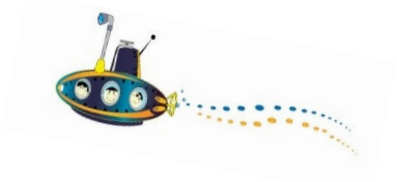
Last visit to a dentist: _____ _____
(Approximate date) (Dentist Name)

What concerns regarding your child's teeth prompted this visit?
_____ I desire comprehensive dental care for my child.
_____ I have specific dental concerns. My concerns are:
_____ My child has complained about dental problems.
_____ My child suffered an injury to the head/mouth/teeth. If so, explain _____
_____

Has your child had any history of the following habits?
_____Thumb-sucking _____Finger-sucking _____Lip-biting ____Nail Biting _____Pacifier
Are any of these habits currently active? YES NO
Child's attitude toward dentistry: _____Favorable _____Unfavorable _____Apprehensive

I understand that the information that I have given is correct to the best of the knowledge and that it will be held in the strictest confidence. It is also my responsibility to inform the office of any changes in my child's medical status. I authorize any Dentist and/or ancillary staff of LeBlanc & Associates to perform the necessary dental services my child may need.

_____ _____
(Signature of parent of guardian) **(Date)**



CONSENT FOR EVALUATION

State Law requires us to obtain your consent for any contemplated dental treatment or oral surgery. However, prior to any treatment, it is necessary to perform a thorough clinical evaluation including any diagnostic aids necessary. Please read this and ask about anything you don't understand. We will be happy to explain it.

I hereby authorize and direct Dr. LeBlanc and/or other designated Associate Dentist, assisted by other dentists and/or dental auxiliaries of his/her choice to perform upon my child (or legal ward) a complete dental examination including the advisable radiographs (x-rays) and any other diagnostic aid deemed necessary by the Dentist in order to properly diagnose the dental condition of my child. I also understand that if any dental treatment is necessary, I will be required to sign consent for treatment after having been explained the proposed treatment.

GENERAL CONSENT FOR TREATMENT

State Law requires us to obtain your consent for contemplated dental treatment. This form serves as a general consent for dental treatment. Please read this form carefully and ask about anything you don't understand. We will be glad to explain it.

1. **After consultation with Dr. LeBlanc and/or other designated Associate Dentist and/or dental auxiliaries and explanation about any proposed procedure, I hereby authorize and direct the treating Dentist, assisted by other Dentists and/or dental auxiliaries of his/her choice to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s) including the necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids:**
   In general terms the dental procedures <u>may include one or a combination</u> of the following:
   - **Cleaning of the teeth and the application of topical fluoride.**
   - **Application of plastic "sealants" to the grooves of the teeth.**
   - **Treatment of diseased or injured teeth with dental restorations.**
   - **Replacement of missing teeth with dental prosthesis.**
   - **Removal (extraction) of one or more teeth.**
   - **Treatment of diseased or injured oral tissues (hard and/or soft).**
   - **Treatment of malposed (crooked) teeth and/or developmental abnormalities**
2. **Alternate methods of treatment, if any, will also be explained to me, as will the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure.**

I hereby state that I have read and understand this consent, and that all questions about this consent or any planned procedures have or will be answered in a satisfactory manner <u>prior</u> to any treatment. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

X _____ _____
Signature of parent or guardian **Date**

_____
Print Name

X _____
Witness

FINANCIAL POLICY

Welcome to the office of LeBlanc & Associates. We want to make your visit productive and enjoyable. We are happy to answer any and all questions regarding insurance plans and payment policies.

I. FINANCIAL POLICY

1. Patients WITH Insurance Coverage:
   - Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for understanding your individual benefits and for the payments of your account.
   - Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due **prior to or at the time of the treatment**.
   - Regarding insurance plans where we are NOT a participating provider, estimates will be collected **prior to or at the time of the treatment** and difference will be billed as necessary.
   - If your insurance company has not paid the claim within 45 days, the balance will be automatically transferred to you.
   - In some cases, insurance carriers may pay for alternative benefits other than the treatment performed and impose frequency limits on procedures your dentist may recommend. In these cases, you are responsible for the costs insurance does not pay.
   - Even if you have dual coverage there may still be a portion that is your responsibility.
2. Patients WITHOUT Insurance Coverage:
   - Patients without insurance coverage are required to pay in full for services rendered at or prior to the time of treatment.

II. CANCELLATION POLICY

- We require a 24-hour cancellation notice for a scheduled appointment.
- Patients who fail to show for their scheduled appointment without giving due notice will be charged a $35.00 fee.

III. BILLING POLICY

- Checks returned unpaid from the bank are subject to $35.00 service fee.
- Accounts delinquent more than 45 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge.
- When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. If your account is sent to our collection agency, you will be responsible for collection and court costs along with attorney's fees.

IV. ACKNOWLEDGEMENT OF UNDERSTANDING

*Please **initial** below to indicate understanding of financial policies:*

_____ *I understand it is my responsibility to know the benefits and limitations of my insurance coverage.

_____ *I understand that some services recommended by my dentist, including but not limited to: x-rays, fluoride, exams, and sealants, may have frequency limitations placed by my insurance. I understand I will be responsible for the costs of these services should my insurance not pay for them.

_____ *I understand my unpaid balance is subject to be turned over to a third-party collections agency, and I will be will be responsible for additional associated fees.

We accept Cash, MasterCard, Visa, and Discover, American Express or Debit/ATM cards and Care Credit. We welcome you to our office and want to provide you with the best care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

BY SIGNING, I AGREE I HAVE READ AND UNDERSTAND *LEBLANC & ASSOCIATE'S* FINANCIAL POLICY, CANCELLATION POLICY AND BILLING POLICY AND THAT I AM THE PERSON RESPONSIBLE FOR THIS PATIENT'S ACCOUNT.

_____ _____

Signature Date

_____

Printed Name

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgment **

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for LeBlanc & Associates. A copy of this signed, dated Acknowledgement shall be as effective as the original.

_____

Please print your name

_____

Please sign your name

_____

Date of your signature

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority

_____ _____

Patients Name Signor's Authority

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer at:

Privacy Officer for
LeBlanc & Associates
15151 S Black Bob Rd
Olathe, KS 66062
Phone: (913)764-5600

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

It was emergency treatment ____

I could not communicate with the patient ____

The patient refused to sign ____

The patient was unable to sign because ____

Other (please describe) ____

_____

Signature of privacy officer