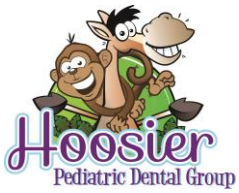

Registration, Insurance & Treatment Consent Form

Patient Name:_____ Patient Date of Birth:_____

Gender: ☐male ☐female	*Preferred* Name:	Social Security #:
Home Address: (Street)_____ (City) _____ (State)_____ (Zip Code) _____ School Name: School Phone #:		Parent/Guardian Name: _____ _____ (Mobile Phone #)
Emergency Contact Name: _____(Relation) _____Daytime Phone # _____ Address (Street, City, State, Zip)_____		

Patient's Primary Insurance

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Social Security #: _____ Group #: _____ ID #: _____

Address of Subscriber: _____
Street City State Zip Code

Name of Employer of Subscriber: _____
Address: _____
Street City State Zip Code Phone #

Patient's relationship to Subscriber: ☐ Self ☐Spouse ☐Child ☐ Other _____

Name of Insurance Plan and Address: _____

Secondary Insurance (if present)

Name of Subscriber: _____ Subscriber's Date of Birth: _____

Subscriber's Social Security #: _____ Group #: _____ ID #: _____

Address of Subscriber: _____
Street City State Zip Code

Name of Employer of Subscriber: _____
Address: _____
Street City State Zip Code Phone #

Patient's relationship to Subscriber: ☐ Self ☐Spouse ☐Child ☐ Other _____

Name of Insurance Plan and Address: _____

Insurance Authorization

Please read, sign, and date below:

Assignment of Benefits and Release of Information

I authorize Hoosier Pediatric Dental Group, LLC to release any and all information contained in my dental/medical records to (a) any health care facility or provider for the purpose of facilitation continuing care and treatment; (b) any third party payer, insurance agencies or carriers or their agents which may be responsible in whole or in part for paying any expenses associated with my treatment; (c) attorneys or agencies representing Hoosier Pediatric Dental Group, LLC in connection with collection actions against insurers, benefit plan, or the patient, or estate; and (d) any federal or state agency as required by law. I assign and authorize direct payment of all health care benefits and other forms of payment of any kind which relate to the care provided to me at Hoosier Pediatric Dental Group, LLC offices for application to my bill(s). I assign to Hoosier Pediatric Dental Group, LLC all claims benefits or any related rights or claims I may have under the Employment Retirement Income Security Act (ERISA) or other applicable law, against any insurer, employee, trustee, fiduciary, employee welfare plan, employee benefit association, or other person who may be liable to pay charges due to Hoosier Pediatric Dental Group, LLC for (my) or my child's care, and agree that the Hoosier Pediatric Dental Group, LLC may pursue any claim to these benefits, whether or not I choose to pursue that claim. I guarantee full financial responsibility for payment of all expenses associated with (my) or my child's care and treatment, including any portion of any charges not paid by insurance, including motor vehicle insurance, worker's compensation or social agencies and agree to pay the same at the time of delivery of service, discharge from treatment, or on any interim basis. These expenses will include but are not limited to deductibles, co-insurance, non-covered benefits services, and services requiring prior authorization which were not authorized.

_____ _____ _____

Signature of Patient or Parent/Guardian **Date** **Relationship to Patient**

Treatment Consent for _____:

Welcome to Hoosier Pediatric Dental Group. Before signing this treatment consent form, please read the following information. If you have questions regarding any of these conditions, please ask a team member for help.

1. Failure to keep appointments may result in the discontinuation of treatment.
2. Failure to be on time for appointments may result in the discontinuation of treatment.
3. Patient records, x-ray, photographs, chart records and other diagnostic aids are the property of Hoosier Pediatric Dental Group, LLC. Duplication of x-rays and chart records is available upon written request along with a processing fee.
4. Treatment expressly for relief of pain, or discomfort, does not commit Hoosier Pediatric Dental Group, LLC to further treatment.
5. I understand that my obligation of payment is due before the services are rendered.
6. I understand that I am accountable for any portion of my bill not covered by my insurance.
7. I authorize payment directly to my dentist.
8. I authorize my dentist to act as my agent in helping me obtain payment from my insurance carrier.
9. I understand that if I receive payment from my insurance carrier for procedures completed in this office, I am responsible for the entire remaining balance at the office.

Consent for Dental Treatment

I give consent for dental treatment for the patient named above to the health care providers of Hoosier Pediatric Dental Group, LLC. I understand there are some risks inherent in all dental procedures, including the administration of local anesthesia and drugs common to dental practice. I understand I am free to ask any questions regarding proposed treatment and risks involved.

_____ _____ _____

Signature of Patient or Parent/Guardian **Date** **Relationship to Patient**

_____ _____

Witness Signature **Date**