WELCOME

Dr. Susan Bracker
1 Saredon Place, Suite 100
Rochester, NY 14606
585-225-5600

TELL US ABOUT YOUR CHILD

CHILDS NAME: _____

CHILDS HOME ADDRESS: _____
_____

CHILDS DOB: _____ AGE: _____ M/F NICKNAME_____

SCHOOL: _____ GRADE: _____

CHILDS PHONE #_____ CHILDS SS#_____

WHO IS ACCOMPANYING THE CHILD?

NAME: _____

RELATION: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

PREVIOUS DENTIST: _____

LAST VISIT: _____

PARENTS MARITAL STATUS: S/ M/ D/ W

PARENTS INFORMATION
>MOTHER/ STEPMOTHER/ GUARDIAN

NAME: _____ DOB: _____

WORK#:_____ HOME#_____

CELL #_____ SS#_____

EMPLOYER: _____

>FATHER/ STEPFATHER/ GUARDIAN

NAME: _____ DOB:_____

WORK#:_____ HOME#_____

CELL #_____ SS#_____

EMPLOYER: _____

PERSON RESPONSIBLE FOR ACCOUNT

NAME: _____
RELATION:_____

BILLING ADDRESS: _____
_____

WORK #_____ HOME#_____

CELL#_____ SS#_____

EMPLOYER: _____

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

NAME: _____

WORK#:_____ HOME#_____

PRIMARY DENTAL INSURANCE

INS. CO. NAME:_____

INS. CO. ADDRESS:_____

INS. CO. PHONE#:_____ GROUP#_____

POLICY OWNER NAME:_____

POLICY OWNER DOB: _____

POLICY OWNER EMPLOYER:_____

RELATIONSHIP TO PATIENT: _____

EMPLOYERS ADDRESS:_____

SECONDARY DENTAL INSURANCE

INS. CO. NAME:_____

INS. CO. ADDRESS:_____

INS. CO. PHONE#:_____ GROUP#_____

POLICY OWNER NAME:_____

POLICY OWNER DOB: _____

POLICY OWNER EMPLOYER:_____

RELATIONSHIP TO PATIENT: _____

EMPLOYERS ADDRESS:_____

WHY DID YOU BRING THE CHILD TO THE DENTIST TODAY?

_____

_____

HAS THE CHILD EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH DENTAL WORK? **YES NO**

IS CHILDS WATER FLUORIDATED? **YES NO**

DOES THE CHILD BRUSH THEIR TEETH DAILY? **YES NO**

FLOSS TEETH DAILY? **YES NO**

CHILDS PHYSICIAN:_____

PHONE:_____ DATE OF LAST VISIT:_____

IS CHILD UNDER CARE OF PHYSICIAN? **YES NO**

PLEASE DESCRIBE CHILDS CURRENT PHYSICAL HEALTH:
GOOD/ FAIR/ POOR

PLEASE LIST ALL DRUGS THE CHILD IS CURRENTLY TAKING?

_____

_____

PLEASE LIST ALL DRUGS CHILD IS ALLERGIC TO: _____

_____

HAS CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

Y / N ABNORMAL BLEEDING
Y / N ALLERGIC TO MEDICATION
Y / N ANEMIA
Y / N HOSPITAL STAYS
Y / N ANY OPERATIONS
Y / N ASTHMA

Y / N CANCER
Y / N CHICKEN POX
Y / N CONGENTIAL HEART DEFECT
Y / N CONVULSIONS/ EPILEPSY
Y / N DIABETES
Y / N EXPOSED TO HIV, BUT NEG.
Y / N HANDICAPS/ DISABILITIES
Y / N HEARING IMPAIRMENT
Y / N HEART MURMUR
Y / N HEPATITIS
Y / N HIV+/ AIDS
Y / N REHEUMATIC/ SCARLET FEVER
Y / N TUBERCULOSIS

ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR IN PRIVATE? **YES NO**

DOES CHILD HAVE ANY OF THE FOLLOWING HABITS?

Y / N LIP SUCKING/ BITING
Y / N NAIL BITING
Y / N THUMB/FINGER SUCKING

I UNDERSTAND THAT THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST OF CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILDS MEDICAL STATUS.

I AUTHORIZE THE DENTAL STAFF TO PERFORM THE NECESSARY DENTAL SERVICES MY CHILD MAY NEED.

SIGN_____

DATE_____

PAYMENT POLICY

1. Payment is expected in full at the time of service, unless arrangements have been made.

2. If you have dental Insurance, you are expected to pay the estimated patient portion at the time of service. If there is an over payment you will be promptly issued a check. If there is a balance due you will be billed at the next billing cycle.

3. If needed, we will provide you with a payment plan. A late fee will be added to your bill after **60** days. **(1.5%)**

4. If we do have to bill you, payment is expected within 15 days. If payment or a telephone call is not received in that time, a $20.00 service charge will be added every billing cycle.

5. Any account over 60 days old will be turned over to a collections agency, unless a payment plan has been arranged and signed.

6. A **$30.00** charge per ½ hour will be applied for any appointment canceled or broken without a 24 hour notification.

7. I agree to pay any late fee on any balances of **60 days** or over **1.5%.**

8. I agree to pay all legal fees if I default on my bill and it needs to be settled in court, this includes attorney fees.

9. There is a $**20.00** duplicating fee if you need us to send your x-rays to another general dentist office.

10. If this bill is not paid in a timely fashion and is sent to collections and or an attorney, I will be responsible for all collection and/or reasonable attorney fees.

SIGN:_____ **DATE:**_____

We have been forced to implement this payment policy as part of our continuing effort to keep costs at a minimum to avoid raising our fee schedule.

I the under signed, have read and understand this payment policy.
SIGN:_____ DATE:_____

DR. SUSAN BRACKER

AS A COURTESY TO ALL OUR PATIENTS:

WE WILL BE CONFIRMING ALL APPOINTMENTS

SENDING OUT POSTCARDS TO REMIND PATIENTS OF UPCOMING APPOINTMENTS

HEALTH INSURANCE PRIVACY PROTECTION ACT (HIPPA)

I have been given the Health Insurance Privacy Protection Act (HIPPA) information. I have been given the opportunity to ask questions and signed a copy, which I am to take home.

SIGNATURE_____

DATE_____

INSURANCE MAXIMUMS

EVERY YEAR THIS PROBLEM IS COMMON TO SOME OF OUR PATIENTS. FOR A FEW PATIENTS WHO REQUIRE EITHER A LOT OF DENTAL TREATMENT OR HAVE INSURANCE THAT PROVIDES A LESSER TOTAL AMOUNT THAN OTHER THIS BECOMES A PROBLEM.

WE DO OUR BEST TO WATCH INSURANCE AND TO HELP GET AN UNDERSTANDING ON INSURANCE. UNFORTUNATELY EACH EMPLOYER HAS A DIFFERENT POLICY, EVERY INSURANCE COMPANY HAS HUNDREDS OF POLICIES THEY PUT TOGETHER TO SELL, AND SOME LARGER COMPANIES WILL OFFER A MULTITUDE OF DIFFERENT POLICIES TO THEIR EMPLOYER.

WE CANNOT KEEP UP WITH EVERYONE'S INSURANCE MAXIMUMS OR THE EXACT COVERAGE OF EACH POLICY. YOU RECEIVE IN THE MAIL A STATEMENT FROM YOUR INSURANCE COMPANY THAT WILL TELL YOU WHAT YOU HAVE USED AND WHAT YOU HAVE REMAINING. PLEASE LOOK AND BECOME FAMILIAR WITH THIS.

I ALSO CANNOT RECOMMEND TREATMENT BASED SOLELY ON THE TYPE OF INSURANCE COVERAGE YOU HAVE AND I CANNOT RECOMMEND HOLDING OFF ON SOME TREATMENT SOLELY DUE TO YOUR INSURANCE COVERAGE OR MAXIMUMS. IT IS YOUR DECISION TO DO TREATMENT OR HOLD OFF ON RECOMMENDED TREATMENT.

SORRY FOR YET MORE PAPERWORK BUT RECENT SITUATIONS HAVE CAUSED ME TO TAKE THE EXTRA STEP TO MAKE IT CLEAR. AS USUAL WE WILL BE WILLING TO HELP YOU INTERPRET YOUR INSURANCE INFORMATION.

NAME_____
DATE_____

PLEASE BE AWARE THAT WE TRY BUT CANNOT BE RESPONSIBLE FOR KEEPING TRACK OF YOUR INSURANCE COVERAGE OR INSURANCE MAXIMUMS

SIGN AND DATE_____

DUE TO NUMEROUS PROBLEMS WITH COLLECTIONS, REALLY NASTY PHONE CALLS AND LETTERS I CAN NO LONGER OFFER PERSONAL PAYMENT PLANS FROM THE OFFICE. **I DO HAVE A VARIETY OF COMPANIES THAT MAY HELP YOU WITH PAYMENT PLANS.** WE WILL GIVE YOU AN APPLICATION. PLEASE BE AWARE THEIR WILL BE CREDIT CHECKS BY THESE COMPANIES.

AT EACH VISIT WE ESTIMATE THE FOLLOWING WILL BE PAID BY YOUR INSURANCE COMPANY.

CLEANINGS, EXAM, X-RAYS IN FULL
(EXCEPT K DENT-1 WHICH COVERS ONLY 80%)

SCALE AND ROOT PLANNING 50%

ALL OTHER DENTAL TREATMENT 50%

FOR THE FEW RARE INSURANCE PROGRAMS LIKE KDENT-2 AND A FEW RETIRED GM PROGRAMS WE KNOW YOU ARE COVERED MORE AND WILL ESTIMATE THE HIGHER PROTION.

AGAIN I AM SORRY TO INSTALL THIS BUT IT HAS BEEN INCREASINGLY DIFFICULT.

IF YOU ARE UNABLE TO PAY YOUR PORTION TODAY PLEASE LET US KNOW BEFORE WE START TREATMENT.

SIGN _____

DATE_____

BILLING STATEMENTS FOR FAMILIES

UNLESS WE ARE INFORMED BY YOU, ALL FAMILY MEMBERS WILL BE BILLED OUT ON ONE SINGLE BILLING STATEMENT.

SHOULD YOU DESIRE TO HAVE SEPARATE STATEMENTS FOR ANY REASON, BE AWARE THAT THE MAILING COSTS OF EACH EXTRA STATEMENT WILL BE ADDED TO YOUR STATEMENT.

SIGN_____

DATE_____

EMERGENCY PATIENTS

MY POLICY IS TO SEE MY PATIENTS THE SAME DAY OR THE NEXT WHEN YOU CALL FOR ANY DENTAL EMERGENCY. HOWEVER, I AM ATTEMPTING TO FIT YOU IN-BETWEEN PATIENTS WITH SCHEDULED APPOINTMENTS. PATIENTS WITH SCHEDULED APPOINTMENTS GET VERY UPSET WHEN THEIR APPOINTMENT IS DELAYED. YOU MAY BE REQUIRED TO WAIT FOR A COMPLETE TREATMENT. I WILL MAKE EVERY EFFORT TO RELIEVE YOUR PAIN AS QUICKLY AS POSSIBLE.

SIGN_____

DATE_____

APPOINTMENTS AFTER 4:00 PM

PLEASE BE AWARE THAT IF DUE TO YOUR SCHEDULE YOU MAY ONLY HAVE AN APPOINTMENT AFTER 4:00 PM, WE DO HAVE A TENDENCY TO RUN BEHIND. A LARGE PERCENTAGE OF PATIENTS HAVE THE SAME NEEDS. IF TIME IS TRULY OF THE ESSENCE INFORM US WHEN YOU CHECK IN AND WE WILL LET YOU KNOW HOW THE SCHEDULE IS RUNNING. IF IT IS AT ALL POSSIBLE PLEASE TRY TO SCHEDULE AN APPOINTMENT AT AN EARLIER TIME.

SIGN_____

DATE_____

TO ALL CHILD HEALTH PLUS (HEALTHPLEX) PATIENTS,

WE HAVE HAD A RECENT PROBLEM WITH PATIENTS FEELING THAT THEY WERE COVERED BY **CHILD HEALTH PLUS** (HEALTHPLEX) AND THEN DISCOVERING THAT THE CONTRACTS HAVE EXPIRED OR THEY HAVE NOT BEEN ENROLLED, OR ASSIGNED TO OUR OFFICE.

IF DENTAL TREATMENTS IS COMPLETED AND YOU ARE NOT COVERED BY CHILD HEALTH PLUS (HEALTHPEX), OR ASSIGNED TO OUR OFFICE, YOU ARE RESPONSIBLE TO PAY FOR THE SERVICE PROVIDED THAT DAY. IF YOU FEEL THEY HAVE MADE A MISTAKE, YOU MUST CALL CHILD HEALTH PLUS (HEALTHPLEX) THEY DO NOT ALLOW US TO CORRECT IT FOR YOU. NEVERTHELESS, ULTIMATELY IF CHILD HEALTH PLUS (HEALTHPLEX) WILL NOT COVER THE SERVICE YOU ARE RESPONSIBLE FOR.

SIGN__________________________________ DATE____________________