

# 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** \_\_\_\_\_