CHILD HEALTH/DENTAL REGISTRATION

Date__________________

Patients Name____ Preferred Name__________________________

Gender M F Date of Birth________________________

Address____ City____________________ State___________ Zip_________________

Phone Number________________________ E-mail____(for appointment confirmation)

Would you like to receive text confirmations? Yes No Phone Number____

Parent/Guardian Name____ Relationship to patient __________________________

Physician____City_________________________Phone______________________

Allergies:

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Local Anesthetic
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Metals
- ☐ Other

Medications:

Please list medications your child is currently taking:

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Has the child had any history of the following:

- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic Anemia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Growth Problems
- ☐ Hearing
- ☐ Heart
- ☐ Hepatitis
- ☐ HIV+ / AIDS
- ☐ Kidney
- ☐ Thyroid
- ☐ Liver
- ☐ Mononucleosis
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Seasonal Allergies
- ☐ Sinusitis
- ☐ Other___________

Child's History

1. Is the child receiving any medical treatment/medications at this time? Yes No
   If yes, please explain____
2. Does the child have any history of serious illness? Yes No
   If yes, please explain____
3. Has the child ever received general anesthetic? Yes No
4. Does the child have any speech difficulties? Yes No
5. Is the child physically, mentally, or emotionally impaired? Yes No
   If yes, please explain____
6. Does the child experience excessive bleeding when cut? Yes No
7. Is this the child's first visit to the dentist? Yes No
8. Has the child had any problem with dental treatment in the past? Yes No
9. Has the child ever suffered injuries to the mouth, head or teeth? Yes No
   If yes, please explain____
10. Has the child had any problem with the eruption or shedding of teeth? Yes No
11. Has the child had any orthodontic treatment? Yes No
    If yes, name of Orthodontist___________________________________City_________________State________
12. What type of water does the child drink? ☐ City Water ☐ Well Water ☐ Bottled Water
13. Does the child take fluoride supplements? Yes No
14. Does the child suck his/her thumb, fingers or pacifier? Yes No

PLEASE COMPLETE BOTH SIDES

PRIMARY INSURANCE INFORMATION

Policy Holders Name____Relationship to Patient____

SS#___________________________________Date of Birth ___________________________Employer___________________________________

Insurance Co.________________________________Phone Number________________________________Group#______________________

Insurance Address____City___________________________State___________Zip____________

SECONDARY INSURANCE INFORMATION

Policy Holders Name____Relationship to Patient____

SS#_________________________________Date of Birth ___________________________Employer____________________________________

Insurance Co.________________________________Phone Number________________________________Group#_______________________

Insurance Address____City___________________________State___________Zip____________

Financial Policy

Dear Patient:

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. Our main concern is that you receive proper and optimal treatment needed to restore your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our office staff. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard and Discover. For your convenience, we do offer financing through Care Credit. We will be happy to help you process your application and your insurance claim for your reimbursement as long as you bring the required information.

Our Financial Policy is as follows:

1. Payment for services is due in full at the time of treatment including any co-payments that are estimated
2. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company
3. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover
4. Fees for these services, along with unpaid deductibles and co-payment are due at the time of treatment
5. If the insurance company does not pay after 60 days, we require you to pay the balance due with cash, check, or credit card
6. Returned checks will be subject to additional fees
7. All balances over 90 days will be reviewed and turned over to an agency for payment or will be sent to our Legal Counsel. You will be responsible for any additional charges incurred
8. We reserve the right to charge a fee of $50 per hour for failed appointments or broken appointment when less than 24 hour notice is received

We understand that temporary financial issues may affect timely payment of your account. We encourage you to communicate any such problems so we may assist you in the management of your account.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentists or any other member of his staff responsible for any action they take or do not take because of error or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature____ **Date**__________________