



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:

Has the child had any history of the following:

- | | | | |
|---------------------------------------------|------------------------------------------|--------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Anemia | <input type="checkbox"/> Heart | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV+ / AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney | <input type="checkbox"/> Seasonal Allergies |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hearing | <input type="checkbox"/> Liver | <input type="checkbox"/> 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? | <input type="checkbox"/> City Water | <input type="checkbox"/> Well Water | <input type="checkbox"/> 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 _____