CHILD'S REGISTRATION

PATIENT REGISTRATION DATE ________

Patient Name ________ Nickname ________ Birthdate ________ Sex M F

Address ________ Phone ________

School ________ Grade ________ Age ________

Father's Name ________ Mother's Name ________

Referred by ________

PERSON RESPONSIBLE FOR THIS ACCOUNT

Responsible Party's Name ________ Relationship to Patient ________

Street Address ________ Phone ________

Employer ________ Years Employed ________ Soc. Sec. No. ________

Business Address ________ Phone ________

FOR PATIENTS COVERED BY INSURANCE

Subscriber's Name ________ Employee I.D.# ________ Birthdate ________ Soc. Sec. No. ________

Employer ________ Business Address ________ Insurance Co. ________

Group No. ________ Deductible Met? Yes No Max. Benefit $ ________ Benefit Year ________

Patient's Relation to Subscriber: Self Spouse Dependent Have You Used Your Dental Insurance This Benefit Year? Yes No

SECONDARY INSURANCE (If covered by more than one dental plan)

Subscriber's Name ________ Employee I.D.# ________ Birthdate ________ Soc. Sec. No. ________

Employer ________ Group No. ________ Insurance Co. ________

Relationship to Patient ________

MISSED APPOINTMENTS

No charge will be made for rescheduling an appointment provided 24 hours notice is given. Otherwise a minimum charge of $25.00 per half hour missed will be incurred. Once an appointment has been made, please remember this time has been reserved specifically for you.

SERVICE CHARGES

Be advised the policy of this office is interest of 1.5% per month (18% ANNUAL PERCENTAGE RATE) will be applied to all accounts over 90 days, regardless of the insurance involvement. There will be a $20.00 handling fee for any RETURNED CHECKS.

INSURANCE ASSIGNMENTS

If this office is able to accept your insurance company's assignment, it does not absolve the patient of full responsibility for the charges in full for the treatment rendered. The estimate provided by this office is considered as a guideline until the final insurance payment is received and the patient's account has been reconciled. This office can make no guarantee of the insurance payment as estimated. The agreed upon payment plan for the patient's estimated portion must be kept current or the assignment will be cancelled and the full amount will become due and payable. Claims are submitted promptly after treatment is rendered, and if not paid by patient's insurance company by the 61st day after treatment, will be billed in full to the patient. Our administrative staff prides itself on helping our patients maximize their benefits. We are always available to answer your questions.

COLLECTION FEES

Fees incurred to enforce payment required by this agreement will be paid by the delinquent client whose failure to pay required said costs to be incurred. Submissions to treatment implies consent as outlined in this service agreement.

FINANCIAL CONSENT

I agree to be fully responsible for total payment of procedures performed in this office, including any treatment not a benefit of any dental insurance the patient may have. I certify I have read, understood, and agreed to this. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

Patient's Signature ________ Date: ________

(Parent/Guardian if patient is a minor)

Dental History

Date of last dental visit ______________________ Type of treatment ______________________

Date of last Bitewing X-Rays ______________________

Does the child have any current dental complaints? .... Yes No

Nature of complaint ______________________

Has the child had any unhappy dental experiences? .... Yes No

Does the child have any mouth habits? .... Yes No

Circle those which apply: Pacifier • Nail Biting • Finger/Thumb sucking • Mouth Breathing

Has the child ever experienced a head injury? .... Yes No

Has the child ever received a tooth or mouth injury? .... Yes No

Please describe injury ______________________

Does your child exhibit any unusual speech habits? .... Yes No

Has your child ever had orthodontic treatment? .... Yes No

When? ______________________

How often does your child brush his/her teeth? ______________________

How often does your child floss his/her teeth? ______________________

Do you assist your child in brushing and flossing? .... Yes No

Is fluoride taken in any form? .... Yes No

How does your child feel about dental visits? ______________________

____

Do you desire complete dental services for your child? .... Yes No

Health History

Is the child currently under the care of a physician? .... Yes No

Name ______________ Phone # ______________

Is the child receiving any medication or drugs? .... Yes No

Has the child ever been hospitalized? .... Yes No

When? ______________ For What? ______________

Is the child allergic to penicillin or any other drugs? .... Yes No

Any other allergies? .... Yes No

What ______________________

Does the child have any emotional problems? .... Yes No

____

Has child any history of or difficulty with any of the following:

Alcohol use	Yes	No	Diabetes	Yes	No	Liver	Yes	No
Anemia	Yes	No	Eating disorder	Yes	No	Malignancies	Yes	No
Asthma	Yes	No	Epilepsy	Yes	No	Measles	Yes	No
Bladder	Yes	No	Fainting	Yes	No	Mononucleosis	Yes	No
Blood transfusion	Yes	No	Hearing	Yes	No	Mumps	Yes	No
Cerebral palsy	Yes	No	Heart/Murmur	Yes	No	Rheumatic fever	Yes	No
Chicken pox	Yes	No	Hepatitis	Yes	No	Thyroid	Yes	No
Chronic sinus	Yes	No	HIV infection (AIDS)	Yes	No	Tobacco use	Yes	No
Convulsions	Yes	No	Kidney	Yes	No	Tuberculosis	Yes	No

Any other medical conditions not listed? .... Yes No

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May we request release of your child's medical records for our reference? .... Yes No

I have answered the above questions to the best of my ability and to the best of my knowledge the information is true and correct. I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Signature ______________ Relation to Child ______________ Date ______________

Staff signature ______________________ Dr. Initial ______________