



Patient Registration

Patient's Name: _____ Date of Birth: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home Phone. # _____ Cell Phone. # _____

Your Employer _____ Work Phone. # _____

Soc. Security #: _____ E-mail address: _____

Marital status: Single Married Widow Separated

Are you a full time student? _____

If patient is a minor, we need: Mother's DOB: _____ Father's DOB: _____

Responsible Party Name: _____

Relationship: _____ Spouse's/Parents: Soc Security # _____

Driver's License #: _____ Spouse's/Parent's Phone #: _____

Emergency Contact name, address and telephone of a relative not living with you:

How did you hear about our office?

Dental Insurance information (Primary)	If you have secondary insurance
Insured's Name:	Insured's Name:
Insured's Employer:	Insured's Employer:
Insurance Company:	Insurance Company:
Phone #:	Phone #:
DOB:	DOB:
SS#:	SS#:
Group #:	Group #:
ID number#:	ID number#:

Patient's Signature (Parent if a minor)

Date



Child's Name: _____ Date of Birth: _____
Child's Primary Care Doctor: _____
Prescription Medications: _____
Herbs/Home Remedies: _____
Allergies: _____

Has your child had any speech issues? _____
Has your child had any feeding/dietary problems(i.e. texture issues, loud, messy eater, picky)?
If so, what? _____

Past Medical History

Does your child have conditions related to any of these symptoms? If so please explain below.

	Yes	No		Yes	No
Lung	<input type="radio"/>	<input type="radio"/>	Developmental Concerns/Learning problems	<input type="radio"/>	<input type="radio"/>
Heart	<input type="radio"/>	<input type="radio"/>	History of ear infections	<input type="radio"/>	<input type="radio"/>
Kidney/Urinary	<input type="radio"/>	<input type="radio"/>	ADHD	<input type="radio"/>	<input type="radio"/>
Bone/Muscles	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>
Gastro-intestinal	<input type="radio"/>	<input type="radio"/>	Genital	<input type="radio"/>	<input type="radio"/>
Eating Disorders	<input type="radio"/>	<input type="radio"/>	Ear/Nose/Throat/Eye	<input type="radio"/>	<input type="radio"/>
Brain/Nervous System	<input type="radio"/>	<input type="radio"/>	Behavioral Problems	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Cold Sores/Fever Blisters	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>

Social History

Frequently Tired	<input type="radio"/>	<input type="radio"/>	Bed Wetting	<input type="radio"/>	<input type="radio"/>
Snore	<input type="radio"/>	<input type="radio"/>	Mouth Breather	<input type="radio"/>	<input type="radio"/>
Regular Headaches	<input type="radio"/>	<input type="radio"/>	Jaw clicking or popping	<input type="radio"/>	<input type="radio"/>
Hard to Wake up	<input type="radio"/>	<input type="radio"/>	Gag easily	<input type="radio"/>	<input type="radio"/>
Grind their teeth	<input type="radio"/>	<input type="radio"/>	Suck their thumb, fingers, hair, etc.?	<input type="radio"/>	<input type="radio"/>

If "Yes" please explain: _____

Are there any other medical conditions or concerns: _____

Patient signature (Parent if child)

Date

Dentist Signature



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____ have read or received a copy of this office's Notice of Privacy Practices. (Copy is in black book on the table in our waiting area or on our website under "Forms")

{Please Print Name}

{Signature}

Guardian Signature

{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself. By signing this, you also allow us to release information to any referring doctor or specialist.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

{Please Print Name}

Relationship

{Please Print Name}

Relationship

{Please Print Name}

Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
 - Communications barriers prohibited obtaining the acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
-



Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist. Checks that are returned to our office from your financial institution are subject to a \$20.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available through CareCredit upon request and approval.

You will have to take responsibility for any fees your insurance has not covered after 60 days. Any expenses incurred in collecting a past due account will be turned over to a collection agency after 90 days which can include attorney fees.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: _____ Date: _____