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CHILD REGISTRATION AND HISTORY

Welcome to our office and thank you for choosing us to help you with your dental health.

*Please complete each of the following items.
 The information that you provide us is strictly confidential
 and will help us know you better and serve you in the best possible way.*

PERSONAL INFORMATION

| | |
|----------------------------------|--|
| Today's Date _____ | Father's Date of Birth _____ |
| Child's Full Name _____ | Father's Social Security # _____ |
| Child's Nickname _____ | Mother's Name _____ |
| Home Address _____ | Mother Employed by _____ |
| City _____ State _____ Zip _____ | Present Position _____ |
| Home Phone No. _____ | Business Address _____ |
| Child's Legal Guardian _____ | City _____ State _____ Zip _____ |
| Child's Date of Birth _____ | Business Phone No. _____ |
| Father's Name _____ | Cell Phone No. _____ |
| Father Employed by _____ | Mother's Date of Birth _____ |
| Present Position _____ | Mother's Social Security # _____ |
| Business Address _____ | Who is responsible for this account? |
| City _____ State _____ Zip _____ | <input type="checkbox"/> Self <input type="checkbox"/> Other _____ |
| Business Phone No. _____ | Whom may we thank for referring you to our office? |
| Cell Phone No. _____ | _____ |

Please feel free to discuss any portion of your dental care with our dental team at any time.

INSURANCE INFORMATION


Emergency Contact _____


| | |
|--|--------------------------------|
| Do you have dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| PRIMARY | SECONDARY |
| Insurance Company _____ | Insurance Company _____ |
| Send Claims to (address) _____ | Send Claims to (address) _____ |
| _____ | _____ |
| Phone No. _____ | Phone No. _____ |
| Insured's Name _____ | Insured's Name _____ |
| Relationship to Patient _____ | Relationship to Patient _____ |
| Insured's Employer _____ | Insured's Employer _____ |
| Insured's Date of Birth _____ | Insured's Date of Birth _____ |
| ID # _____ | ID # _____ |
| Group # _____ | Group # _____ |


DENTAL HISTORY


| | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| Date of last visit to a dentist _____ | | | Any lost teeth due to unusual circumstances?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| For what service? _____ | | | Have missing teeth been replaced?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Has child complained about dental problems?..... | <input type="checkbox"/> | <input type="checkbox"/> | Orthodontic appliances worn now or ever been?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| What problems? _____ | | | Does your child brush their teeth daily?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Any unhappy dental experiences?..... | <input type="checkbox"/> | <input type="checkbox"/> | Do you assist child with tooth brushing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | How often? _____ | | |
| Any injuries to mouth/teeth/head?..... | <input type="checkbox"/> | <input type="checkbox"/> | Is dental floss used?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | | How often? _____ | | |
| Any mouth habits: thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.?..... | <input type="checkbox"/> | <input type="checkbox"/> | Is fluoride taken in any form?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>(Please Circle)</i> | | | What form? _____ | | |
| Any unusual speech habits?..... | <input type="checkbox"/> | <input type="checkbox"/> | Do you desire complete dental service for the child?.... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Do we have your permission to use Nitrous Oxide (Laughing Gas) if the doctor deems it necessary?..... | <input type="checkbox"/> | <input type="checkbox"/> |

Child's attitude to dentistry:









HEALTH HISTORY

| | |
|--------------------------------|----------------------------------|
| Child's Physician's Name _____ | Phone No. _____ |
| Physician's Address _____ | Date of Last Physical Exam _____ |

| | YES | NO | | YES | NO |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Is child under care of physician now?..... | <input type="checkbox"/> | <input type="checkbox"/> | Does child require antibiotic medication for | | |
| For what condition? _____ | | | Dental Treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Is child receiving any medication or drugs?..... | <input type="checkbox"/> | <input type="checkbox"/> | Dental Cleanings?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Describe _____ | | | Is there any allergy to penicillin or other drugs?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Is there excessive bleeding when cut?..... | <input type="checkbox"/> | <input type="checkbox"/> | Describe _____ | | |
| Has child ever been hospitalized?..... | <input type="checkbox"/> | <input type="checkbox"/> | Are there other allergies: food, pollen, animals, dust, latex, acrylic?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| When? _____ | | | Describe _____ | | |
| Has child ever had surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> | Does child have good physical coordination?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| When? _____ | | | Are there any emotional problems?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Has child tested positive for HIV virus/AIDS?..... | <input type="checkbox"/> | <input type="checkbox"/> |

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:
(Please check all that apply)

| | | | | | |
|---|--|---|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Hearing | <input type="checkbox"/> Mastoid | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bladder | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other _____ | | | |

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

Parent's Signature _____ Date _____

Doctor's Signature _____

PAYMENT POLICIES

It is our goal to provide the best possible dental care for our patients. Your financial concerns are important to us. We, therefore, offer the following financial arrangements. We will make every effort to enable you to enjoy the benefits of the best dental care available.

Assignment of Insurance: We understand the value of insurance benefits to our patients and we gladly accept assignment of those benefits. We will do our best to estimate your deductible and the portion that may be covered by your insurance carrier. Please keep in mind that rarely does an insurance company cover an entire fee, and that each carrier sets their own limitations on the maximum amount they will pay for each procedure **based on the type of policy purchased by your employer.** Any balance remaining is your direct responsibility, as are any noncovered charges, deductibles or copayments. It is the policy of our office that you leave a payment at each visit equal to your estimated balance. We do not accept any insurance carrier's fees as payment in full. Since it is impossible for us to be familiar with the details of every insurance plan, we ask that you be aware of your financial responsibilities under the terms of your policy.

Retainers for Treatment Involving Lab Work: We do require a retainer of half the fee for any treatment involving laboratory work. (e.g., crowns, bridges, dentures, nightguards, laminates, etc.)

Courtesy for Payment In Full on Date of Treatment: We are able to pass on the savings of not having to send you a statement if payment in full is made at the time services are rendered. With this payment option, we extend a courtesy of 7% for payment made by cash or check only. With this savings program, there is no assignment of benefits to our office. Payment will be made directly to you by your carrier.

Senior Citizen Courtesy: We do offer a senior citizen courtesy to people age 62 and over of 10% if payment is made by cash or check at the time services are rendered. There will be a 5% courtesy if a credit card is used.

Outside Financing: Our office has contracted with a finance company so that we can offer you several attractive payment options. The qualification process is simple and can usually be completed while you are in our office. You have the choice of making payments over a three, six or twelve month period with 0% financing.

Finance Charge: If your balance with us is not paid in full within 60 days from the monthly billing date, a finance charge will be added to your account for the current monthly billing period. The finance charge will be at a periodic rate of 1.5% per month which is an annual percentage rate of 18%.

Your signature below is evidence that you have read and are aware of our office financial policy.

Responsible Party's Signature _____ Date _____

FOR OFFICE USE ONLY

MEDICAL AND INFORMATIONAL HISTORY UPDATE

Please review your attached Medical History.

Since your last visit, has there been any change in 1) your medical history, 2) medication or pills, 3) have you been seeing a health care practitioner or physician, 4) do you have a change of address, phone number, employer, insurance company, etc.?

Date _____

Signature _____ Relationship _____

Date _____

Signature _____ Relationship _____

Date _____

Signature _____ Relationship _____

Date _____

Signature _____ Relationship _____

Date _____

Signature _____ Relationship _____
