CHILD Registration Form

Patient Name: _____ **Date:** _____
Last Name First MI Preferred Name

Home Address: _____

Birth Date: _____ **Sex:** _____ **Name of School Attending:** _____

Social Security Number: _____

Mother's Name: _____ **Father's Name:** _____

Contact #'s Home: _____ **Best time to call:** _____

Names of immediate family members: _____

Nearest Relative: _____ **Phone:** _____

Perferred Appointment Times: ☐ **Morning** ☐ **Afternoon** ☐ **Evening** ☐ **Anytime** ☐ **M** ☐ **T** ☐ **W** ☐ **TH** ☐ **F** ☐ **S**

Email Address: _____

Health Information

Previous Dentist: _____ **Date of Last Dental Visit:** _____

Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artifical Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Mitral Valve Prolapse
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis Type:
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due Date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____

Please list all medications you are now taking: _____

Have you ever had any complications following dental treatment? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Have you ever been admitted to a hospital or needed emergency care during the past two years? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Are you now under the care of a physician? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Name of Physician: _____

Do you have any health problmes that need further clarification? ☐ **Yes** ☐ **No**
If yes, please explain: _____

Whom may we thank for referring you to our practice? _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes to my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of patient, parent or guardian Date

Responsible Party Information

Name of person financially responsible: _____

Relationship to patient: _____

Social Security # _____ **Birthdate:** _____

Address: _____

City, State & Zip Code: _____

Method of payment: ☐ **Cash** ☐ **Check** ☐ **Credit Card**

Bank: _____ **Account #** _____

Credit Card: _____ **Account #** _____

Employment Information

Employer Name: _____ **Occupation:** _____

Employers Address: _____ **Phone:** _____

Spouse Employer: _____ **Occupation:** _____

Employers Address: _____ **Phone:** _____

Insurance Information

Primary

Name of Insured: _____ **Is insured a patient?** ☐ **Yes** ☐ **No**

Insured's Birth Date: _____ **Insured's Social Security Number:** _____

Insurance ID #: _____ **Group #:** _____

Insured's Address: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ **Is insured a patient?** ☐ **Yes** ☐ **No**

Insured's Birth Date: _____ **Insured's Social Security Number:** _____

Insurance ID #: _____ **Group #:** _____

Insured's Address: _____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's accoount. However, this dental office cannot renderservices on the assumption that our charges will be paid by an insurance company.

A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previous written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonalble value of said services to said Doctor, or his assignee, at the time said serrvices are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for paymetn thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. "IN THE EVENT OF NON-PAYMENT OR DEFAULT, I AM RESPONSIBLE FOR ALL COST OF COLLECTIONS, INCLUDING BUT NOT LIMITED TO COLLECTION AGENCY FEES, COURT COST, AND REASONABLE ATTORNEY FEES."

I grant my permission for you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____

Signature of guarantor/responsible party of payment | Date | Relationship to patient