



New Patient Registration - Child

PERSONAL INFORMATION

Today's Date:

Last Name:

First Name:

Preferred Name:

Gender: Male Female

Date of Birth:

Social Security Number:

Mailing Address:

City:

State:

Zip Code:

Phone Number:

(best contact number for appointment confirmations)

PARENT/GUARDIAN INFORMATION

Who is responsible for the account?: Last Name: First Name:

Relationship to child: Mother Father Legal Guardian Other:

Address (if different from above):

Home Phone: Cell Phone: Work Phone:

Email:

Employer: Occupation:

Employer Address:

City:

State:

Zip Code:

How did you hear about us?:

Child's present/past dentist: Last Visit Date:

Does your child have dental insurance? Yes No

If yes, please provide the office staff with a copy of your card.



MEDICAL HISTORY

Physician's Name: Phone Number:

Child's current physical health is: Good Fair Poor

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

If yes, please explain:

Is your child taking any prescription or over-the-counter medications?: Yes No

If yes, please list:

Has your child ever taken Fosamax, Phen-fen, or any bisphosphonate?: Yes No

Is your child allergic to any of the following?:

- Aspirin
- Chlorhexidine
- Codeine
- Dental Anesthetics
- Erythromycin
- Iodine
- Jewelry
- Latex
- Metals
- Penicillin
- Tetracycline
- Other

Has your child ever had any of the following diseases or medical problems?

<ul style="list-style-type: none"> <input type="checkbox"/> Abnormal bleeding <input type="checkbox"/> Arthritis <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Congenital heart defect <input type="checkbox"/> Emphysema <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Heart attack (family history) <input type="checkbox"/> Hemophilia <input type="checkbox"/> High blood pressure <input type="checkbox"/> Liver disease <input type="checkbox"/> Pacemaker <input type="checkbox"/> Rheumatic/scarlet fever <input type="checkbox"/> Sickle cell disease/traits <input type="checkbox"/> Thyroid problems <input type="checkbox"/> Venereal disease 	<ul style="list-style-type: none"> <input type="checkbox"/> Alcohol/drug abuse <input type="checkbox"/> Artificial bones/joints/valves <input type="checkbox"/> Cancer/chemotherapy <input type="checkbox"/> Diabetes <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart murmur <input type="checkbox"/> Hepatitis (what type:) <input type="checkbox"/> HIV+/AIDS <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Psychiatric problems <input type="checkbox"/> Seizures <input type="checkbox"/> Sinus problems <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Other _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Asthma <input type="checkbox"/> Colitis <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Fainting spells <input type="checkbox"/> Hay fever <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Herpes/fever blisters <input type="checkbox"/> Kidney problems <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Radiation treatment <input type="checkbox"/> Shingles <input type="checkbox"/> Stroke (family history) <input type="checkbox"/> Ulcers
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DENTAL HISTORY

Your child's current dental health is: Good Fair Poor

How many times a day does your brush?: How many times a week does your floss?:

Type of bristles: Soft Medium Hard

Is your child's water fluoridated?: Yes No

Emergency Contact Name:

Phone Number: Relation:

The information I have provided on this form is correct to the best of my knowledge.

Signature of Parent of Guardian: Date:



FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a 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.

- Payment is due at the time of service.
- If you have insurance, we expect you to pay your estimated portion at the time of service.
- We accept cash, checks or credit cards.
- We offer an extended payment plan with prior credit approval.

Insurance

We are an out-of-network provider for all insurance benefits and we file your insurance claims for you as a courtesy. Your insurance policy is a contract between you and your insurance company and it is your responsibility to ensure we have correct and current insurance information. Please be aware that some of the services we provide may not be covered under your insurance policy. We do require that you pay your estimated portion and deductible at the time of service. Once your insurance company has paid your benefits, you are responsible for any remaining balance.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary to our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Late Fees and Collection Costs

If a payment is not paid within the terms of an agreed upon payment plan, Carbondale Family Dental may assess a delinquency charge in an amount not exceeding the greater of 10% of the unpaid amount of the installment not to exceed \$15.00 provided that such charge may be collected at the time it accrues or any time thereafter but only one such charge shall be made for each installment in default regardless of the length of the period it remains unpaid.

In the event of any default, Carbondale Family Dental may declare the entire unpaid balance to be immediately due and payable. If Carbondale Family Dental then assigns this agreement to a collection agency for recovery, the patient will also be responsible for up to 30% of the unpaid principle balance as the reasonable cost of collection.

Minor Patients

The adult accompanying a minor is responsible for payment.

Missed Appointments

We ask that you please call at least 24 hours in advance if you cannot keep your appointment. If you miss appointments, we ask that you provide a credit card to secure your future appointment. A fee will be assessed for repeated missed appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions regarding this policy.

I have read, understand, and agree to this Financial Policy. In the event that my account is turned over to a collection agency, I agree to pay all reasonable collection fees and court costs.

Signature of Parent of Guardian:

Date:



HEALTH PRIVACY NOTICE

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

I acknowledge that I have received a copy and/or read the Carbondale Family Dental Notice of Privacy Policies.

Signature of Parent of Guardian:

Date: