CHILD'S REGISTRATION AND HISTORY
(PLEASE COMPLETE BOTH SIDES)

CHILD'S NAME_____
FIRST MIDDLE LAST

ADDRESS_____

CITY:_____STATE:_____ZIP_____

HOME PHONE NUMBER (INCLUDING AREA CODE)_____

EMAIL ADDRESS (PLEASE PRINT)_____

PRIMARY DENTAL INSURANCE_____POLICY HOLDER:_____

POLICY NUMBER:_____GROUP NUMBER:_____

SECONDARY DENTAL INSURANCE_____POLICY HOLDER:_____

POLICY NUMBER:_____GROUP NUMBER:_____

FATHER'S FULL NAME:_____
FIRST MIDDLE LAST

FATHER'S SS#:_____FATHER'S BIRTHDATE:_____/_____/_____BUSINESS PHONE:_____

FATHER'S CELL PHONE #:_____

FATHER'S EMPLOYER:_____HOW LONG?_____

FATHER'S DRIVER'S LICENSE#:_____STATE:_____

ADDRESS:_____
(IF OTHER THAN CHILD'S)

MOTHER'S FULL NAME:_____
FIRST MIDDLE LAST

MOTHER'S SS#:_____MOTHER'S BIRTHDATE:_____/_____/_____BUSINESS PHONE:_____

MOTHER'S CELL PHONE #:_____

MOTHER'S EMPLOYER:_____HOW LONG?_____

MOTHER'S DRIVER'S LICENSE#:_____STATE:_____

ADDRESS:_____
(IF OTHER THAN CHILD'S)

PERSON FINANCIALLY RESPONSIBLE IF OTHER THAN PARENT:_____

RELATIONSHIP TO CHILD:_____

ADDRESS:

HOME PHONE #:_____BUSINESS PHONE #:_____

EMPLOYER:_____SS#_____

DRIVER'S LICENSE #:_____STATE_____

THANK YOU FOR TRUSTING US AS YOUR CHILD'S DENTAL HEALTH CARE PROVIDER. WE APPRECIATE YOUR TRUST AND THE OPPORTUNITY TO SERVE YOU. IT IS OUR GOAL TO PROVIDE THE BEST POSSIBLE CARE FOR YOUR CHILD. IN ORDER FOR US TO MEET THIS GOAL, WE MUST HAVE YOUR HELP. PLEASE CAREFULLY READ THE FOLLOWING GUIDELINES FOR OUR OFFICE.

APPOINTMENTS: ONCE AN APPOINTMENT IS MADE PLEASE REMEMBER THAT THIS TIME HAS BEEN RESERVED ESPECIALLY FOR YOUR CHILD. WE EXPECT AT LEAST 48 HOURS NOTICE PRIOR TO CHANGING OR CANCELING AN APPOINTMENT SO THAT WE MAY ACCOMMODATE OTHER PATIENTS AWAITING TREATMENT. THE MORE ADVANCE NOTICE YOU GIVE US, THE MORE CAPABLE WE ARE OF FINDING A MORE APPROPRIATE APPOINTMENT TIME FOR YOU. APPOINTMENTS BROKEN OR CANCELED ON SHORT NOTICE MAY NOT BE ABLE TO BE RESCHEDULED FOR SEVERAL WEEKS. PLEASE UNDERSTAND THAT AFTER 3 MISSED APPOINTMENTS WE MAY ASK YOU TO FIND ANOTHER DENTAL OFFICE THAT BETTER MEETS YOUR SCHEDULE NEEDS.

ALSO, WE CANNOT EXPECT PATIENTS WHO HAVE ARRIVED ON TIME FOR THEIR APPOINTMENTS TO WAIT WHILE WE "WORK IN" PATIENTS WHO ARRIVED LATE WHEN YOU ARE UNAVOIDABLY LATE FOR YOUR CHILD'S APPOINTMENT. WE MAY BE ABLE TO OFFER A LATER APPOINTMENT TO YOU, OR WE MAY NEED TO RESCHEDULE YOUR CHILD'S APPOINTMENT. PLEASE UNDERSTAND THAT WE MAKE EVERY EFFORT TO BE ON TIME FOR YOUR CHILD'S APPOINTMENT, HOWEVER, EMERGENCIES DO ARISE, ESPECIALLY WHEN WE ARE DEALING WITH CHILDREN. WE HOPE THAT YOU WILL UNDERSTAND ANY DELAYS THAT MAY OCCUR, SINCE WE WOULD DO THE SAME IF YOUR CHILD WERE THE ONE WITH THE EMERGENCY.

PAYMENT. TO AVOID MISUNDERSTANDING, WE WISH THE PERSONS RESPONSIBLE FOR THE PATIENT'S ACCOUNT BE AWARE THAT ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED DIRECTLY TO THEM AND THAT THEY ARE PERSONALLY RESPONSIBLE FOR PAYMENT OF FEES AT THE TIME OF SERVICE. FOR THOSE THAT DO HAVE DENTAL INSURANCE, IF YOU PROVIDE OUR OFFICE WITH COMPLETED DENTAL CLAIM FORMS, WE WILL BE HAPPY TO KEEP THESE IN YOUR CHILD'S CHART AND HAVE THEM READY FOR FILING FOR DIRECT REIMBURSEMENT TO THE SUBSCRIBER. PLEASE UNDERSTAND THAT OUR OFFICE DOES NOT PARTICIPATE WITH ANY INSURANCE COMPANY. DENTAL INSURANCE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE DO NOT RENDER OUR SERVICES ON THE BASIS THAT INSURANCE COMPANIES WILL PAY OUR FEES. HOWEVER, IN THE EVENT THAT AN EXTENSIVE TREATMENT PLAN HAS BEEN DETERMINED NECESSARY FOR YOUR CHILD, OUR OFFICE WILL GLADLY WORK WITH YOU TO MAKE FINANCIAL ARRANGEMENTS.

I (WE) HAVE READ AND UNDERSTAND THE ABOVE OFFICE POLICIES CONCERNING APPOINTMENTS AND PAYMENT: I (WE) AGREE TO ABIDE BY THESE POLICIES.

FATHER'S SIGNATURE_____

DATE

MOTHER'S SIGNATURE_____

DATE

RELEASE OF INFORMATION: I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION ACQUIRED DURING THE EXAMINATION OR TREATMENT TO INSURANCE COMPANY (IES), AND TO ANY OTHER PHYSICIAN(S) OR DENTIST(S) INVOLVED IN THE PATIENT'S CARE.

PATIENT OR GUARDIAN SIGNATURE:_____

DATE