REGISTRATION FORM

Today's Date _____

Responsible Party (Main contact person for scheduling, billing)

Name_____

Relationship to Patient_____

Preferred Name_____

Phone Numbers:

H_____

W_____

C_____

Email_____

Birthday_____

Address

_____

City_____ State_____ Zip _____

Social Security #_____

Employer_____

Occupation_____

How may we contact you?

Home Phone [ ] Cell Phone [ ] Work Phone [ ] Email [ ] Text Message [ ]

Alternate Contact

Name_____

Relationship to Patient_____

Preferred Name_____

Phone Numbers:

H_____

W_____

C_____

Birthday_____

Social Security #_____

How did you hear about our office? (Check all that apply)

[ ] Social Media [ ] Internet Search (Google, Yelp, Website, etc)

[ ] Insurance Provider [ ] Mailer

[ ] Referred by a Patient: _____

[ ] Magazine/Phonebook: _____

[ ] Referred by a Medical/Dental office: _____

[ ] Other: _____

Child/Children Information

Child's Name _____

Preferred Name _____

Birthday_____Gender_____Age_____

Medicaid or CHP+ ID Number_____

Child's Name _____

Preferred Name _____

Birthday_____Gender_____Age_____

Medicaid or CHP+ ID Number_____

Child's Name _____

Preferred Name _____

Birthday_____Gender_____Age_____

Medicaid or CHP+ ID Number_____

Child's Name _____

Preferred Name _____

Birthday_____Gender_____Age_____

Medicaid or CHP+ ID Number_____

Child's Name _____

Preferred Name _____

Birthday_____Gender_____Age_____

Medicaid or CHP+ ID Number_____

Child's Name _____

Preferred Name _____

Birthday_____Gender_____Age_____

Medicaid or CHP+ ID Number_____

Child's Name _____

Preferred Name _____

Birthday_____Gender_____Age_____

Medicaid or CHP+ ID Number_____

Child's Name _____

Preferred Name _____

Birthday_____Gender_____Age_____

Medicaid or CHP+ ID Number_____

Primary Dental Insurance

Name of Insurance_____

Insurance Phone #_____

Name of Subscriber_____

Insured's Birthday_____

If different from responsible party; please fill out the information below:

Insured's Social Security #: _____

Insured's
Employer:_____

Subscriber ID #:_____

Secondary Dental Insurance

Name of Insurance _____ Insurance phone #_____

Name of Subscriber _____ Insured's Birthday _____

Subscriber ID # _____If different from responsible party, please fill out the information below:

Insured's Social Security # _____ Insured's Employer: _____

Please provide the front office with a copy of your insurance card. These cards contain information that is required for us to be able to bill your insurance. We realize if you have Delta Dental or MetLife that you may not have a card.

Financial and Insurance Policy

We are dedicated to providing our patients with the optimum treatment available and we base our decisions on what is best for your child and not on what your insurance will or will not pay.

Our relationship is with you. We are happy to bill your insurance company as a courtesy to you. It is your responsibility to know the details of your particular policy. We will present you with a treatment plan that has an estimate of your out of pocket cost. This is an estimate only. Any amount not covered by your insurance will be your responsibility.

Payment is due at the time services are provided. We accept cash, personal checks and all major credit cards.

Financial Option: We accept Denefits and Care Credit. This is a cost effective, no interest way for you to pay for all medical expenses.

Information can be found at: www.denefits.com and www.carecredit.com.

Financial Obligation: We allow 90 days for your insurance to make a payment to us. After this time any outstanding balance will be your responsibility. Any questions regarding what your insurance company has or has not paid should be directed to your insurance company. Once payment has been received from your insurance company if you have a balance, we will send a statement to you. If the balance has not been paid within two weeks a $20 billing fee will be assessed. If your outstanding balance has not been received after another 2 weeks you will be assessed a new 20$ billing fee. If your account is not paid in full by another 2 weeks you will be assessed another 20$ billing fee, your account will be turned over to a collection agency without further notice, and you will be responsible for a 35% collection fee. If case of split financial responsibility, such as divorce, the parent who brought the child into the office is responsible for the full payment. It is this parents responsibility to be reimbursed from the other parent/custodian.

Notice to Parents: You may allow your child to have prizes at their own risk. **Warning:** Items in the treasure chest may pose a choking hazard. Small prizes are not for children under 3 years old. Prizes may also contain unknown and/or harmful materials. Parents accept **all** responsibility and will not hold Treasured Teeth or its employees liable.

Child play area is not supervised by our staff at Treasured Teeth; It is the responsibility of the parent to monitor your child's safety while they are in the waiting area, on the pirate ship or playing on the video games. Parents accept **all** responsibility and will not hold treasured teeth or its employees liable.

I have read the office policies and had any questions answered. I agree to the terms and conditions.

Parent (Guardian) Signature: _____ Date:_____

Acknowledgment Of Receipt Of

Notice of Privacy Practices

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

I, (please print parent/guardian name) _____

have received a copy of this office's Notice of Privacy Practices to read and/or take home.

_____

Please print your child(ren)'s name(s)

_____

Parent/Guardian's signature

_____

Today's date

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:

_____ The individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)_____

_____

Missed Appointment Policy

Our goal is to provide quality individualized dental care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to dental care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment: Thank you for respecting the time of our highly trained and specialized doctors and the office employees. Missed appointments are very costly as there are many professionals waiting to provide your child with outstanding individualized treatment. In order to be respectful of the dental needs of other patients, please be courteous and call the office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your general appointment we require that you call at least 48 business hours in advance. Conscious sedation appointments must be canceled one week in advance and General Anesthesia appointments must be canceled **two weeks** in advance. Appointments are in high demand and your early cancellation will allow another patient access to timely medical care. Again, your assistance is greatly appreciated.

How to Cancel Your Appointment: To cancel your appointment, please call 303-853-9955. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Late Cancellations and "No Shows": A cancellation is considered to be late when the appointment is cancelled without the notice listed above. The following fees will be assessed for late cancellations and "no shows." After the 3rd occurrence of late cancellation or "no show" the below fee will be assessed and the patient may be discharged from the practice.

No Show Fees:

General Appointment: $200

Conscious Sedation Appointment: $300

General Anesthesia Appointment: $500

No Show Policy: If you miss an appointment without cancelling it or fail to be present at the scheduled time it will be recorded in the patient's chart as a "no-show" and the above fees will apply.

Signature: _____ Date: _____

Medical History

Child's Name:_____

Today's Date:_____

Were there any difficulties during pregnancy, delivery, or first year of life? (Including premature birth) Yes [ ] No [ ]

If yes, please explain:

_____
___

_____
___

Who is your child's Physician?
_____

Physicians phone number:_____

Is a physician treating your child for a specific illness? Yes [ ] No [ ] Please explain:

_____
___

_____
___

Has your child taken medications in the past? Yes [ ] No [ ] Please list:
_____

Is your child currently taking any medications? Yes [ ] No [ ] If yes, please list:

_____
___

Has your child ever been hospitalized? Yes [ ] No [ ] If yes, please explain:

_____
___

Has your child ever had surgery? Yes [ ] No [ ] If yes, please explain:

_____
___

Was general anesthesia used? Yes [ ] No [ ] explain any complications:

_____
___

_____
___

Does your child have any allergies? Yes [ ] No [ ] if yes, please list:

Is your child allergic to latex? Yes [ ] No [ ]

Are your child's immunizations up to date? Yes [ ] No [ ]

Has your child had any of these occurrences or been diagnosed with any of these conditions?

	Yes	No		Yes	No		Yes	No
Aids/HIV			Chronic Headaches			Heart Murmur		
Anemia			Chronic Ear Infections			Hemophilia		
Asthma			Cleft Lip/Palate			Hepatitis /Liver Disease		
Autism			Congenital Heart Disease			Hyperactivity		
Bladder Condition			Developmental Delay			Kidney Disease		
Blood Transfusion			Diabetes			Leukemia		
Birth Defect			Emotional Disturbances			Mental Retardation		
Bone/Joint Issues			Epilepsy/Seizure			Nutritional Deficiency		
Brain Injury			Eye Problems			Oral Ulcers		
Bruising Easily			Excessive Bleeding			Orthopedic		
Cancer			Excessive Gagging			Rheumatic Fever		
Cerebral Palsy			Fainting/Dizziness			Scoliosis		

Child Abuse			Growth Issues			Sickle Cell Anemia		
Chronic Tonsillitis/Adenoid			Hearing/Speech Problems			Tuberculosis		

Dental History

Child's name: _____

Date of Birth: _____

Has your child been to the dentist before?……..……....Yes [ ] No [ ]

1. When was his/her last visit to the dentist? _____

Were x-rays taken at his/her last visit…….……Yes [ ] No [ ]

2. Has your child had any cavities in the past.....Yes [ ] No [ ]

3. Has he/she had any problems with dental treatment in the past?...……Yes [ ] No [ ]

4. Has your child had a negative dental experience in the past?.....Yes [ ] No [ ]

5. Has he/she ever had sealants placed by a dentist?.....Yes [ ] No [ ]

6. How often does your child eat/drink sweets? (Candy, Soda, Cookie, Juice)

[ ] Rarely [ ] Once a day [ ] Frequently

7. How many times a day does your child brush his/her teeth? _____

8. When does your child brush his/her teeth?

[ ] Morning [ ] After eating any food [ ] After meals [ ] Before going to bed

9. Does your child have bad breath? …… Yes [ ] No [ ]

10. Please check any of the following habits your child has:

[ ] Thumb or Finger sucker [ ] Lip sucking or biting [ ] Pacifier

[ ] Mouth breathing [ ] Bottle in bed [ ] Grinding

11. Has he/she ever experienced any dental injuries? [ ] Yes [ ] No

if yes please describe,

_____

12. What is most important to you about your child's dentist and dental care?

_____

13. Do you or your child have any concerns about his/her teeth?

_____

I hereby give my permission to Treasured Teeth to provide dental treatment for my child that the doctor deems necessary and appropriate. Routine treatment may include, but may not be limited to: cleanings, x-rays, fluoride, topical and local anesthetic (injections), nitrous oxide etc.

Signature of legal guardian: _____

Date: _____

Consent Form

Publish Photos / Video of Minors

Reunion Pediatric Dentistry asks your permission to use photos and videos for our website, social media and for marketing only. It is our policy that we will never reveal or use the names and surnames of minors when we post photos and videos. Parents have the right to grant or refuse permission when it comes to their child (ren).

- ❑ Yes, I agree to allow permission for **Reunion Pediatric Dentistry** to take photos or video of my child (ren).
- ❑ No, I do not give permission for **Reunion Pediatric Dentistry** to take photos or video of my child (ren).

Name of your child(ren)

_____

_____

Parent/Guardian's Name

_____

_____

Signature _____

Date_____