Davis Family Dental, LLC

CHILD REGISTRATION FORM

Patient's full name _____ Date_____

Parent's/Guardian's name_____ Relationship to Patient _____

Address (PO or mailing address) _____

City/State/Zip _____ Email: _____

Phone: (home) _____ (work) _____ (cell) _____

Gender: M____ F____ Social Security #: _____ Date of Birth _____

DENTAL INSURANCE INFORMATION

Do you have dental insurance (please circle)? Yes No

Primary Ins: Insurance Co. _____ Subscriber DOB: _____
Subscriber: _____ Subscriber Employer: _____
Subscriber SS#: _____ Do you have Secondary Ins? Yes No

CHILD'S HEALTH/DENTAL HISTORY

Has the child had any history of, or conditions related to, any of the following:

___ Anemia	___ Epilepsy	___ Mononucleosis	___ Chicken Pox	___ Cerebral Palsy
___ Arthritis	___ Fainting	___ Mumps	___ Chronic Sinusitis	___ Immunizations
___ Asthma	___ Growth Problems	___ Pregnancy (teens)	___ Diabetes	___ Tobacco/Drug Use
___ Bladder	___ Hearing	___ Rheumatic fever	___ Ear Aches	___ Measles
___ Bleeding disorders	___ Heart	___ Seizures	___ Kidney	___ Tuberculosis
___ Bones/Joints	___ Hepatitis	___ Sickle Cell	___ Latex Allergy	___ Venereal Disease
___ Cancer	___ HIV+/AIDS	___ Thyroid	___ Liver	___ Other _____

Child's medical physician: _____ Phone: _____

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? …… Yes No
   If yes, please explain _____
2. Is the child allergic to any medications (penicillin, antibiotics or other drugs)? ..... Yes No
   If yes, please explain_____
3. Is the child allergic to anything else, such as certain foods? …… ..... Yes No
   If yes, please explain _____
4. How would you describe the child's eating habits? _____
5. Has the child ever had a serious illness? ……..... Yes No
   If yes, when and describe illness: _____
6. Has the child ever been hospitalized? ……..…… Yes No
   If yes, please explain _____
7. Does the child have any speech difficulties?..…….... Yes No
8. Is the child physically, mentally, or emotionally impaired?..... Yes No
9. Does the child experience excessive bleeding when cut?……..... Yes No
10. Is this the child's first visit to a dentist?..... Yes No
    If not, please list the date of last dental visit: _____
11. Has the child had any problem with dental treatment in the past?..... Yes No
12. Has the child ever suffered any injuries to the mouth, head or teeth? …… Yes No
13. Has the child had any problems with the eruption or loss of teeth? …… Yes No
14. Has the child had any orthodontic treatment? …….. Yes No
15. Does the child take fluoride supplements? …… Yes No
16. Does the child suck his/her thumb, fingers or pacifier? ……...Yes No
17. How many times are the child's teeth brushed per day? _____ Does the child floss daily?..... Yes No

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status

Doctor's use only: _____
_____

Signature of Parent or Legal Guardian: ___ Date_____

CONSENT FOR TREATMENT

1. I hereby authorize Dr. Davis or designated staff to take x-rays, study models, photographs and/or any other diagnostic aids deemed appropriate to make a thorough diagnosis of _____'s dental needs.
(name of patient)

2. Upon such diagnosis, I authorize Dr. Davis to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account.

4. I agree that photos are a part of my dental record. Photos taken by Davis Family Dental, LLC may be used for case presentations as well as continuing education. Before/After photos may be used to present future case studies to patients, used on your dental web site, as well as in your office slide show. I hereby give you permission to use the following type of photos:

Teeth_____ Face_____

Signature of Parent or Legal Guardian: ___**_____**Date_____

METHOD OF PAYMENT / FINANCIAL POLICY / CANCELLATION-DISMISSAL POLICY

Thank you for choosing Davis Family Dental, LLC. Taking care of you and your family is our highest priority. An important part of that priority is making the cost of optimal care as easy and manageable as possible. Please note below our method of payment options available to use to pay for your dental treatment.

- Cash or Check: 5% discount for treatment paid in full prior to completion
- Credit or Debit Card: Visa or MasterCard
- Monthly payment plan: Short or Long Term financing available through CareCredit

1. All fees are payable at the time of service. I understand that insurance is provided as a service to me as a patient of Davis Family Dental, LLC, and that I am ultimately responsible for payment of service rendered, including any and all collection fees incurred.

2. I authorize my insurance carrier to issue the dental benefits to my plan directly to this dental office and authorize the release of any information necessary to process dental insurance.

3. I understand that insurance coverage is an ESTIMATE only and that my insurance is a contract between me and my insurance company and/or employer.

4. A finance charge of 1.5% per month may be assessed to accounts with balances outstanding for 60 days from treatment date. This finance charge represents an APR of 18%.

5. I understand that due to the high patient volume, it is a policy that upon **3 missed or failed appointments**, Davis Family Dental, LLC, reserves the right to discontinue treatment to me as a patient.

Signature of Parent or Legal Guardian: _____**Date:** _____