Webster Dental Care

CHILD REGISTRATION FORM

PATIENT INFORMATION:

Today's Date: _____

Child's Name: _____ Nickname:_____
LAST, FIRST

Date of Birth_____ Gender: Male □ Female □ Social Sec #: _____

Address: _____
STREET CITY , STATE ZIP

Phone: _____ Has your child been to the dentist before? _____

Emergency contact not living in household:_____

Are the parents or siblings Webster Dental Patients? _____

RESPONSIBLE PARTY:

Name of person responsible for this account: _____

Relationship to patient: _____ Email: _____

Home Phone: _____

Cell Phone: _____

Social Security #: _____ Driver's License #:_____

PARENTAL AND INSURANCE INFORMATION:

Father: Name: _____ Birth Date:_____
LAST, FIRST

Address if different from child: _____
STREET CITY, STATE ZIP

Employer: _____ Work Phone:_____

Work Address: _____

Father is the insured? □ YES □ NO Social Security #: _____

Name of Employer: _____ Insurance Co: _____

Group #: _____ ID#: _____ Ins. Phone #: _____

Claims Address: _____

Mother: Name: _____ Birth Date:_____
LAST, FIRST

Address if different from child: _____
STREET CITY, STATE ZIP

Employer: _____ Work Phone:_____

Work Address: _____

Mother is the insured? □ YES □ NO Social Security #: _____

Name of Employer: _____ Insurance Co: _____

Group #: _____ ID#: _____ Ins. Phone #: _____

Claims Address: _____

How did you hear about our office?

□ Friend/Relative
□ Current Webster Patient
□ Dental Insurance
□ Computer Search
□ Mailing
□ Social Media Site _____

Who may we thank for referring you to our office?_____

DENTAL HISTORY:

Purpose of Today's Visit?

□ First Check Up
□ Regular Check up, radiographs (if needed), cleaning and fluoride treatment
□ Emergency Visit

Please describe Emergency: _____

□ Referral from another dentist. (reason for referral): _____

If the child has had any unfavorable dental visits please describe: _____

_____

Child's Physician:_____ Doctor's Phone#: _____

Any hospitalizations (reason and date): _____

Any difficulties with pregnancy or child's birth? _____

Please list all medicines child is taking: _____

_____

Please check if your child has been treated or has had difficulty with any of the following conditions:

□ Anemia
□ Asthma
□ HIV/Aids
□ Bleeding Disorders
□ Cerebral Palsy
□ Cancer
□ Birth Defects
□ Cleft Lip/Palate
□ Developmental Delay
□ Diabetes
□ Epilepsy
□ Fainting
□ Heart Disease
□ Heart Murmurs
□ Kidney Disease
□ Liver Disease
□ Physical Delays
□ Rheumatic Fever
□ Seizures
□ Speech/Hearing Issues
□ Allergies
□ Personality/Social Issues
□ Other

Please elaborate on any items checked or any health behavior issues we should know about:

_____

Please certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status.

Signature of Patient or Guardian: _____ Date: _____

CONSENT FOR TREATMENT:

1. I hereby authorize Doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed necessary to make a thorough diagnosis of _____'s dental needs.
   NAME OF PATIENT

2. Upon such diagnosis, I authorize the Doctor and/or Hygienist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware that this office provides optimal care as recommended by the ADA and my dental insurance may not cover certain procedures. It is my responsibility to be aware of what is covered by my insurance.

3. I agree to the use of anesthetics and other medications as necessary. I fully understand that the use of said agents imposes certain risks and realize that it is necessary to inform the doctor and staff of any drugs, including recreational drugs that I may be taking in order to minimize these risks.

4. A fee if $1.00 per minute of appointment time will be charged if an appointment is cancelled without 24 hours notice.

Please note: In the event of divorced situations, we will look to the parent or guardian who signs this form for payment unless we have these forms signed by the other parent and a letter that the other parent is accepting full responsibility for the services done to your child. It is our goal to provide your child optimal dental care and not get in the middle of your divorce issues.

Child's name: _____

Patient or Guardian (Printed): _____

Signature of Patient or Guardian: _____ Date: _____

FINANCIAL AND OTHER POLICIES:

I understand that payments for all services are to be paid at the time of service unless different payment arrangements are made in advance. We will work with you if we have confirmed dental insurance and collect only the **estimated** copayment at the time of service. We make no guarantee that the amount we collect is accurate. We estimate the collected copayment from historical data. If you want a more accurate estimate, ask to have **a pretreatment estimate** to your insurance company. We will gladly submit your insurance claim to the insurance address you gave us. If we do not get paid within 30 days of submission of the claim we will look to you for full payment of your bill. Once we reach your annual maximum benefit, we will look to you for complete payment at the time of service unless a written payment plan has been made. We accept cash, checks, money orders and all major credit cards for your payments.

Assignment of Benefits: I hereby authorize my insurance company to pay directly to Webster Dental Care benefits accruing to me under my policy. A service charge of 1.5% per month (18% per annum), but in no event more than the maximum rate permissible under state laws will be charged on the unpaid principle balance on all accounts not paid within 60 days of the treatment date. I further understand the fee estimates listed for my dental care can only be extended for a period of six months from the date the estimate was written.

After 90 days from the date of service any unpaid accounts will be referred to a collection agency. I will then be responsible for my balance plus an additional 30% of the unpaid balance as the agency fee and any attorney's fees. I grant my permission to you, or your assigns to telephone me at my home or place of employment to discuss matters related to this form, my treatment or billing issues.

I understand that there is a $1.00 per minute of appointment time charged for appointments cancelled with less than 24 hours notice.

Please silence your cell phones when in the treatment rooms.

Warning: Do not sign this if you have any questions about the financial policies of our offices. If you have any questions, ask one of our financial coordinators before signing this paper.

In accordance with HIPAA, I agree to the disclosure of my protected health information to my insurance company. I authorize my insurance company to pay Webster Dental directly.
I have read the above Financial and Other Policies and agree to the content.

Child's name: _____

Signature: _____ Date: _____
PARENT OR GUARDIAN

Webster Dental Care Acknowledgement of Receipt of Notice of Privacy Practice:
(Please notify clerk if you refuse to sign this Acknowledgement)

I, _____have received a copy of the office's Notice of Privacy Practice.

Printed Name: _____

Signature: _____ Date: _____
PARENT OR GUARDIAN