

CHILD REGISTRATION

The Colony Pediatric & Adolescent Dentistry

Date: _____

PATIENT INFORMATION

Child's Name _____ DOB _____ M ___ F ___ Medicaid # _____

Address: Residence _____ Apt # _____ City _____

State _____ Zip _____ Phone (____) _____ Has child seen a dentist before? _____

If yes, where and were there any unfavorable experiences? _____

How did you find out about us? _____

FAMILY INFORMATION

Mother's Name _____ DOB _____ Marital Status M / S

Home Address _____ City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____ Fax _____ Cell/Pager _____

Email _____ Social Security # _____ Employer _____

Present Position _____ How long held _____

Employer's Address _____

City _____ State _____ Zip _____ Phone _____

Father's Name _____ DOB _____ Marital Status M / S

Home Address _____ City _____ State _____ Zip _____

Business Address _____

Telephone: Res. _____ Bus. _____ Fax _____ Cell/Pager _____

Email _____ Social Security # _____ Employer _____

Present Position _____ How long held _____

Employer's Address _____

City _____ State _____ Zip _____ Phone _____

May we request release of your child's medical records for our reference? () yes () no

Emergency Information: Name of nearest relative _____

Address _____ Phone _____

INSURANCE INFORMATION

DENTAL INSURANCE FIRST COVERAGE:

Employee Name _____ DOB _____

Employer Name _____

Insurance Company Name _____

Claim Mailing Address _____

City _____ State _____ Zip _____ Phone _____

Employee ID # _____ Group # _____

DENTAL INSURANCE SECOND COVERAGE:

Employee Name _____ DOB _____

Employer Name _____

Insurance Company Name _____

Claim Mailing Address _____

City _____ State _____ Zip _____ Phone _____

Employee ID # _____ Group # _____

CONSENT/ AUTHORIZATION

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care:

My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor. It is understood and agreed by me that I will pay all Attorney Fees and other costs necessary for the collection of any amount not paid by me when due.

I understand that where appropriate, credit bureau records may be obtained.

I understand that cancellations require 24 hrs. notice for regular appointments and 72 hours for sedation treatment appointments. Failure to provide timely cancellation notice will incur a charge of \$30.

It is understood that the Parent/Guardian accompanying the patient is responsible for payment at the time of treatment.

Parent/Guardian Signature _____ Date _____