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 ___________________________________