CHILD / YOUTH REGISTRATION

Name of Patient _____ SS# _____
First Middle Last

Date of Birth _____ Age _____ Home # (___) _____

Father's Full Name _____ SS# _____ Work # (___) _____

Mother's Full Name _____ SS# _____ Work # (___) _____

Home Address _____ City _____ Zip _____ E-Mail Address _____

Past Dental Service (check): ❑ None ❑ Emergency Only (why _____) ❑ Regular ❑First Visit _____

School _____ School Grade _____

Person Responsible for Account _____ Relationship _____

Social Security Number _____ Occupation _____

Employer _____ Work # (___) _____

Employer's Address _____

Do you have Dental Insurance? Yes _____ No _____ With Whom? _____

Nearest Relative Not Living With You _____ Relationship _____

Address _____ Zip _____ Phone # (___) _____

Recommended By _____

The following information is important for the patient's maximum safety, comfort and optimum dental care. This information will be held in the utmost confidence by this office. Please answer yes or no to the following:

1. Is the patient presently under the care of a physician? ❑ **Yes** ❑ **No**
2. Has the patient ever had abnormal bleeding following a wound? ❑ **Yes** ❑ **No**
3. Is the patient allergic to ❑ **Penicillin/Amoxicillin** ❑ **Latex** ❑ **Sulfur** ❑ **Codeine** ❑ **Other**: _____
6. Does the patient have any limiting disabilities? ❑ **Yes** ❑ **No** If so, what? _____
7. Has the patient ever had any of the following?

a) Rheumatic Fever	❑ Yes ❑ No	**h) Tuberculosis**	❑ Yes ❑ No
b) Rheumatic Heart Disease	❑ Yes ❑ No	**i) Diabetes**	❑ Yes ❑ No
c) Congenital Heart Disease	❑ Yes ❑ No	**j) Liver Trouble or Jaundice**	❑ Yes ❑ No
d) Blood Disorder	❑ Yes ❑ No	**k) Heart Murmur**	❑ Yes ❑ No
e) Epilepsy or Convulsions	❑ Yes ❑ No	**l) Hepatitis**	❑ Yes ❑ No
f) Asthma or Hay Fever	❑ Yes ❑ No	**m) Eczema or Hives**	❑ Yes ❑ No
g) Mitral Valve Prolapse	❑ Yes ❑ No	**n) HIV (Aids)**	❑ Yes ❑ No

8. Does the patient have any history of missing teeth? ❑ **Yes** ❑ **No**
9. Has the patient been under the care of a physician for any major illness or injury other than those noted above ❑ **Yes** ❑ **No**
   If so, what? _____

I give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes of dental treatment for the child named above in my absence.

Initial

_____ **I acknowledge that I have been given or offered a copy of the offices "Notice of Privacy Practices."**

I understand that payment is due at the time of service and that I am fully financially responsible for all charges.

_____ **I understand that if my account is sent to collections I will be responsible for a $65 collection fee and any attorney fees and court cost associated.**

I will pay today by: ❑ CASH ❑ CHECK ❑ CREDIT CARD ❑ OTHER

Signature: _____ Date: _____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.

Insurance Information / Release Form

Policy Holder's Information

❑ Male ❑ Female	/ /	- -
Policy Holder's Name	Birth Date	Social Security Number
❑ Male ❑ Female	/ /	- -
Spouses Name	Birth Date	Social Security Number

Insurance Information

Employer	Address	City	Zip	Phone Number
Insurance Company	Address	City	Zip	Phone Number

ID Number	Group Number	Plan Number

Dependent's Name (last name if different than yours)

❑ Male ❑ Female	/ /	
Dependent	Birth Date	
❑ Male ❑Female	/ /	
Dependent	Birth Date	
❑ Male ❑ Female	/ /	
Dependent	Birth Date	

Secondary Insurance Information

❑ Male ❑ Female	/ /	- -		
Policy Holder's Name	Birthday	Social Security Number		
Employer	Address	City	Zip	Phone Number
Insurance Company	Address	City	Zip	Phone Number

ID Number	Group Number	Plan Number

Please Initial:

_____ I authorize release of any information relating to my claim.

_____ I authorize payment directly to Down to Earth Dental.

_____ I understand that all fees not paid by insurance are my responsibility.

Print Patient Name	Patient or Guardian Signature	Date

Failed Appointment & Short Notice Cancellation Policy

Down to Earth Dental takes great pride in providing high quality dental care.
When we schedule your appointment we do so in a way that we can spend quality time with you.
It is also a priority to us that we see you promptly at your appointment time.
We ask the same courtesy of you.

Please be aware of our policy regarding no-shows and last minute cancellations.

When an appointment is cancelled without at least a
24 hour notice or you fail to arrive for your appointment,
you will be charged $45 (per hour) for a missed appointment fee.

*If a two hour appointment is set aside for you,
we ask that you give a 48 hour notice.

If two appointments are missed we reserve the right to discontinue seeing you at this office.

I, _____ understand and agree to the following policy.
(Patient or Guardian Printed Name)

X_____ _____
Signed (Patient or Guardian) Date