

Welcome! The benefits of a healthy and happy smile are immeasurable. Our goal is to help you reach and maintain this. In order for us to properly evaluate your dental and medical health, we request that you fill out **all** parts of this registration form. We believe that the better we communicate, the better we can care for you.



Childs Information

Boy Girl

Today's Date _____

First Name		Middle	Last Name		Birthdate / /	Social Security # - -
Name of responsible party(Mother,Father,Step-Parent,Grandparent,etc)				Cell Phone#	Drivers License #	State
Childs Address			Number	Street		Home Phone#
City		State	Zip	(Area Code) Phone	Preferred Mode of Apt. Confirmation Circle one below: Phone/ E-Mail/ Text Message	
Occupation of Responsible Party			Employer			
Employer's Address		Number	Street			
City		State	Zip	(Area Code) Phone		
Pharmacy Name			Pharmacy Phone #			

Parent's Information

Dad's Name		Dad's Birthday & SS#		Dad's Cell Phone#
Mom's Name		Mom's Birthday & SS#		Mom's Cell Phone#
Whom May we Thank for Referring You to us?			Where have you seen our Advertising?	
What Radio Station do you listen to?		Do you read a local paper?		
In Case of an Emergency, Person to Notify		Relationship	(Area Code) Phone	
Is Mom, Dad or Sibling's Currently a patient in our office?		Please Complete Insurance Information on Page 2		

Please describe your primary reason for today's visit (your concerns):

How long has this been going on and what would you like done?

If you could rate your child's smile from 1-10, what would it be? ____

Would you like to improve your child's smile? YES NO How? _____

INSURANCE INFORMATION If you have any type of dental insurance, please complete the following section.

Name and address of Insurance company			(Area Code) Phone
Employee/Subscriber Name	Relationship to Employee (check one): __Self __Spouse __Child __Other	Sex: __M __F	If Full-Time Student- School & City
Dental Plan Name	Group #	Employee/Subscriber #	
Is Patient covered by Another Dental Plan __Yes __No	Dental Plan Name	Group #	
Name and address of other Insurance company			(Area Code) Phone

<p>IF YOU WANT US TO ACCEPT YOUR INSURANCE ASSIGNMENT, PLEASE SIGN BELOW.</p> <p>I authorize the release of any necessary information regarding my dental health to my dental insurance companies. I hereby authorize payment directly to Bartlett Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am fully responsible for any portion of my bill not paid by my dental insurance company within sixty days of claim being submitted or my account will be turned over collection and I will be charged an additional \$135-\$300 collection processing fee.</p> <p>Signature: _____</p>	<p>I acknowledge that payment is due at the time of treatment, unless other arrangements are made in advance. I agree that parents, guardians or personal representative are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing an insurance claim within my insurance company does not relieve me from my responsibility for the payment of all charges. We estimate the patient portion due at time of treatment.</p> <p>Signature: _____</p>
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If you are unable to meet the above requirements, please ask to speak with the office manager to reschedule your appointment. For your convenience, we accept cash, personal checks, major credit cards and Care Credit. There will be a \$30 Service charge for all returned checks. Please present your current insurance card to our receptionist. We copy all cards to verify dental coverage. Should you have a loss or change in coverage it is your responsibility to notify our office and present a new card.

Notice of Privacy Practices and Acknowledgement

In the course of providing service to you ,we create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. Your signature on this form indicates that you are giving permission for your Personal Health Information to be disclosed to someone other than yourself.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our

By signing this form, you consent to us to leave appointment information with someone other than yourself via phone, answering machine, email and/or sent to you by postcard.

Please list specific name(s) who you would want to receive information about your appointments and/or treatment. If you do not list anyone below, you are allowing us to confirm your appointments with anyone who may answer your phone. If you do not want us to leave this information with anyone other than yourself, please write "no one" on the line below.

Name (s)

You may revoke this authorization at any time by notifying Bartlett Family Dentistry in writing. This revocation is only effective after it is received and logged by Bartlett Family Dentistry.

Signature

Date

Witness