Mendelson Family Dentistry

CHILD PATIENT REGISTRATION FORM

☐ Male ☐ Female

Date: _____

PATIENT NAME: _____Date of Birth: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Email: _____

Mother's Information:
Name: _____ Date of Birth: _____
Home: _____ Cell: _____Work: _____
SSN: _____

Father's Information:
Name: _____ Date of Birth: _____
Home: _____ Cell: _____Work: _____
SSN: _____

Party Responsible for Payment:
Name: _____ Phone: _____
Home Address: _____
Relationship: _____
Employer: _____ Phone: _____

_____
Signature of responsible party

I am legally responsible for any charges and agree to payment of service charges and any unpaid balance over 90 days.

Primary Dental Insurance Information (if applicable)
Group/ Employer Name: _____ Group #: _____
Insurance Company Name: _____ Phone #: _____
Address: _____
Employee (Policy Holder): _____ Relationship to Patient: _____
Subscriber ID#: _____ Policy Holder Birth Date: _____

Secondary Dental Insurance Information
Group/ Employer Name: _____ Group #: _____
Insurance Company Name: _____ Phone #: _____
Address: _____
Employee (Policy Holder): _____ Relationship to Patient: _____
Subscriber ID#: _____ Policy Holder Birth Date: _____

Whom may we thank for referring you? _____
Who is responsible for making appointments? _____
Home phone: _____Cell: _____
Work: _____ Email: _____

HEALTH HISTORY

Date of last dental examination: _____ Date of last dental x-rays: _____
Previous Dentist's Name: _____
Date of last physical examination: _____ Physician's Name: _____
Please list all medications your child is currently taking, include over the counter, vitamins and herbal remedies: _____
_____

Has the child had any history of or condition related to any of the following:

☐ Anemia	☐ Hepatitis
☐ Arthritis	☐ HIV/AIDS
☐ Asthma	☐ Immunizations
☐ Bladder	☐ Kidney
☐ Bleeding Disorders	☐ Latex Allergy
☐ Bones/ Joints	☐ Liver
☐ Cancer	☐ Measles
☐ Cerebral Palsy	☐ Mononucleosis
☐ Chicken Pox	☐ Mumps
☐ Chronic Sinusitis	☐ Pregnancy (teens)
☐ Diabetes	☐ Rheumatic Fever
☐ Ear Aches	☐ Seizures
☐ Epilepsy	☐ Sickle Cell
☐ Fainting	☐ Thyroid
☐ Growth problems	☐ Tobacco/ Drug Use
☐ Hearing	☐ Tuberculosis
☐ Heart	☐ Developmental Delay

☐ Other _____

Why did you bring your child to the dentist today? _____

Is the child taking any prescription or over the counter medication or vitamin supplements at this time?
If yes, please list: _____ ☐ Yes ☐ No
Is the child allergic to any medications, i.e penicillin, antibiotics or other drugs?
If yes, please list: _____ ☐ Yes ☐ No
Is the child allergic to anything else such as certain foods?
If yes, please explain: _____ ☐ Yes ☐ No
Has the child ever had a serious illness?
If yes, please explain: _____ ☐ Yes ☐ No
Does the child brush his/her teeth every day? ☐ Yes ☐ No
Floss his/her teeth daily? ☐ Yes ☐ No
Is the child's water fluoridated? ☐ Yes ☐ No
Is the child taking fluoridated supplements? ☐ Yes ☐ No
Has the child had any problem with dental treatment in the past? ☐ Yes ☐ No
Is there anything related to your child's medical or dental history that you have not indicated above?
_____

The following are current policies in effect for patients of Mendelson Family Dentistry:

1. All insurance co-pays, deductibles and personal payments are due at the time of your visit. If you elect to do a procedure not covered by your insurance, you are responsible for all charges incurred for the procedure.
2. You must present a current active insurance card at the time of your visit. If you do not have your insurance card, payment of the procedure is due in full on the date of service and can be submitted to your insurance company upon proof of insurance.
3. All accounts 90 days past due will be charged 1.5% interest rate per month until the balance is paid in full.
4. If your insurance lapses or you do not have active coverage you are responsible for all charges incurred while you are without insurance.
5. Self-pay parties must pay at the time of service. Financing is available through Care-Credit.
6. To cancel an appointment, you MUST give at least 24-hour notice or a $75 cancellation fee will be assessed.
7. If you miss three or more appointments without providing advance notice, you will only be seen for emergency appointments.

_____ _____

Signature of Responsible Party Date