Welcome! Happy you're here. Thought you should know that we have Pediatric Dental Specialists here to care for children. Ask your Treatment Coordinator about our many Specialists here and available for you.

Revised 05/0/2017

Patient Registration Form

Patient Personal Info

Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		DL#	
City, State, Zip				Cell #		Work #	
				Student		SS #	
Email				School Name			
				Referral Type			
Parent Responsible/Guarantor for paying bills							
Title		Nickname		Birth Date		Age	
Last, First				Marital Status		Sex	
Address				Home #		DL#	
				Cell #		Work #	
City, State, Zip				SS #			
Email							

Do you have Primary Dental Insurance? Y / N		Do you have Secondary Dental Insurance? Y / N	
Group No/Name		Group No/Name	
Insurance Name		Insurance Name	
Insurance Phone		Insurance Phone	
Employer Name		Employer Name	
Subscriber/Policy Holder Last, First		Subscriber/Policy Holder Last, First	
Subscriber/Policy Holder Address		Subscriber/Policy Holder Address	
City, State, Zip		City, State, Zip	
Relationship to Patient		Relationship to Patient	
SSN/Subscriber ID		SSN/Subscriber ID	

Financial Policy

Thank you for choosing **Lovett Dental** as your dental healthcare provider. We are committed to providing you with the highest quality dental health care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, Master Card, Visa, and Discover. Outside financing is available upon request and approval. Please check ☐ if you would like more information about financing options.

Please note: Returned checks will be subject to additional fees. In case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges up to 35%.

Do you Have Insurance?

- As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- We are committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount not covered by your insurance company, with an approved payment method listed above at the time we provide the service to you.
- Insurance Payments are ordinarily received within 30-60 days from the date of filing the claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- I understand that account balances over 30 days will incur an interest charge at the maximum legal rate allowed.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

Consent:

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment of Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance rebilling, collection charge and/or attorney fee will be added to any overdue balance.

Patient Signature (Parent if Child) Date

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Children's Dental & Medical History

Name		Date		Account#	

Dental and Medical Questionnaire

YOUR CHILD'S DENTAL AND MEDICAL HISTORY – Complete for patients 17 years and younger. Place comments in space below.

Is your child currently in pain?	Y / N	Describe the conditon of your childs teeth and gums	[ ] Good [ ] Fair [ ] Poor	
Why have you come to the dentist today?		Do any of the following apply to your child?		
Child's first dental visit	☐	Swelling or injury to the mouth or face		Y / N
Preventative follow up	☐	Bad dental experience or treatment		Y / N
Check up	☐	Bottle, Pacifier, finger, thumb, or other Oral habits		Y / N
Second Opinion	☐	Explain		
Special Referral Service	☐			
Other	☐			
Explain				

Has your child ever had any of the following?		Use this space for comments
Ever been hospitilized?	Y / N	
Ever had a siginificant injury?	Y / N	
Ever been seriously ill?	Y / N	
Ever received blood/blood products?	Y / N	
Ever had surgery?	Y / N	
Does your child have a heart murmur or congenital heart disease?	Y / N	
Sickle Cell Disease or trait	Y / N	
Asthma, cystic fibrosis, respitory disease?	Y / N	
Speech or hearing disorder?	Y / N	
Liver Disease/Hepititus/Jaundice?	Y / N	
Autism, ADHD, genetic disorder sydrome?	Y / N	
Kidney Disease?	Y / N	
Skin, bone, muscle or joint disease?	Y / N	
Seizures/convulsions/loss of consciousness?	Y / N	
Sexually transmitted disease or HIV?	Y / N	
Cancer?	Y / N	
Diabetes, thyroid, glandular, or other endocrine disease?	Y / N	
Sight or Eye disorder?	Y / N	
Frequent headaches?	Y / N	
Mental, emotional or developmental delays?	Y / N	
Snoring or loud breathing?	Y / N	
Frequent Infections of any type?	Y / N	
Does your child take any medicine?	Y / N	

Is your child allergic to any foods, enviromental polutants, animals, medicines? Please List

Is there any other disease or medical condition we should know about in order to care for your child? Please List

Which of the following describes your child's learning abilites	How do you think your child will cooperate for this appointment?
[ ] Delayed [ ] Normal [ ] Advanced	[ ] Well behaved [ ] Unsure [ ] Uncooperative
Your child's primary care physician name and number	

Parent/ Guardian Reviewed – Signed

_________________________________ _____________

Signed by Date

FOR FUTURE FOLLOW-UP HISTORY UPDATE – ONLY

Have there been any **changes to your child's health** since your last visit to our office? If so please list below

1. Date ____________________ Changes Y N Initials _______________
2. Date ____________________ Changes Y N Initials _______________
3. Date ____________________ Changes Y N Initials _______________