



REGISTRATION FORM

Today's Date _____

Responsible Party (Main contact person for scheduling, billing)

Name _____ Relationship to Patient _____

Preferred Name _____

Phone Numbers H _____ W _____ C _____

Email _____ Birthday _____

Address _____

City _____ State _____ Zip _____ Social Security # _____

Employer _____ Occupation _____

How may we contact you? Home Phone [] Cell Phone [] Work Phone [] Email [] Text Message []

Alternate Contact

Name _____ Relationship to Patient _____

Phone Numbers H _____ W _____ C _____

Birthday _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

How did you hear about our office? (check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Mailer | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Internet Search (Google, Yelp, Website, etc) | <input type="checkbox"/> Insurance Provider |
| <input type="checkbox"/> Referred by a Patient: _____ | <input type="checkbox"/> Magazine/Phonebook: _____ |
| <input type="checkbox"/> Referred by a Medical/Dental office: _____ | <input type="checkbox"/> Other: _____ |

Child/Children Information

Child's Name _____ Nickname _____

Birthday _____ Gender _____ Age _____

Medicaid or CHP+ ID Number _____

Child's Name _____ Nickname _____

Birthday _____ Gender _____ Age _____

Medicaid or CHP+ ID Number _____

Child's Name _____ Nickname _____

Birthday _____ Gender _____ Age _____

Medicaid or CHP+ ID Number _____

Primary Dental Insurance

Name of Insurance _____ Insurance phone # _____

Name of Subscriber _____ Insured's Birthday _____

Subscriber ID # _____ If different from responsible party, please fill out the information below:

Insured's Social Security # _____ Insured's Employer: _____

Secondary Dental Insurance

Name of Insurance _____ Insurance phone # _____

Name of Subscriber _____ Insured's Birthday _____

Subscriber ID # _____ If different from responsible party, please fill out the information below:

Insured's Social Security # _____ Insured's Employer: _____

Please provide the front office with a copy of your insurance card. These cards contain information that is required for us to be able to bill your insurance. We realize if you have Delta Dental or Metlife that you may not have a card.

Financial and Insurance Policy

We are dedicated to providing our patients with the optimum treatment available and we base our decisions on what is best for your child and not on what your insurance will or will not pay.

Our relationship is with you. We are happy to bill your insurance company as a courtesy to you. It is your responsibility to know the details of your particular policy. We will present you with a treatment plan that has an estimate of your out of pocket cost. This is an estimate only. Any amount not covered by your insurance will be your responsibility.

Payment is due at the time services are provided. We accept cash, personal checks and all major credit cards.

Financial Option: We accept Care Credit. This is a cost effective, no interest way for you to pay for all medical expenses.

Information can be found at www.carecredit.com.

Financial Obligation: We allow 90 days for your insurance to make a payment to us. After this time any outstanding balance will be your responsibility. Any questions regarding what your insurance company has or has not paid should be directed to your insurance company. If we have not received a payment from you after another 90 days your account will be turned over to a collection agency without further notice and you will be responsible for a 35% collection fee. In case of divorce, the parent who brought the child into our office is responsible. It will be up to you to get reimbursed from the other parent.

Notice to Parents: You may allow your child to have prizes at their own risk. **Warning:** Items in the treasure chest may pose a choking hazard. Small prizes are not for children under 3 years old. Prizes may also contain unknown and/or harmful materials. Parents accept **all** responsibility and will not hold Treasured Teeth or its employees liable.

Child play area is not supervised by our staff at Treasured Teeth; It is the responsibility of the parent to monitor your child's safety while they are in the waiting area, on the pirate ship or playing on the video games. Parents accept **all** responsibility and will not hold treasured teeth or its employees liable.

I have read the office policies and had any questions answered. I agree to the terms and conditions.

Parent (Guardian) Signature: _____ Date: _____

Treasured Teeth
Pediatric Dental Specialist
**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

***** You May Refuse to Sign This Acknowledgement*****

I, (please print parent/guardian name) _____
have received a copy of this office's Notice of Privacy Practices to read and/or take home.

Please print your child(ren)'s name(s)

Parent/Guardian's signature

Today's date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ The individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify) _____

Missed Appointment Policy

Our goal is to provide quality individualized dental care in a timely manner. No-shows, late shows and cancellations inconvenience those individuals who need access to dental care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment: In order to be respectful of the dental needs of other patients, please be courteous and call Dr. Tippet's office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your regular scheduled appointment, we require that you call at least 48 business hours in advance. If your appointment is for conscious sedation, appointments need to be canceled one week in advance, and for a General Anesthesia appointment, appointments need to be canceled **two weeks** in advance. Appointments are in high demand, especially specialized appointments, and your early cancellation will allow another patient access to timely medical care.

How to Cancel Your Appointment: To cancel your appointment, please call 970-240-8694. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Late Cancellations: A cancellation is considered to be late when the appointment is cancelled without the notice listed above, and the following fee schedule will apply in the event of a missed appointment:

General Appointment: \$200

Conscious Sedation Appointment: \$300

General Anesthesia Appointment: \$500

No Show Policy: A "no-show" is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". This includes arriving 10 minutes after your scheduled appointment.

The first time there is a "no-show", late cancellation, or cancellation without a reasonable excuse there will be no charge to the patient. A 2nd occurrence will result in a fee of the visit. The 3rd occurrence will be the fee of the visit and the patient may be discharged from the practice.

For our New Patient's first visit, a no show or late cancellation will result in a full charge of the new patient fee.

Signature: _____ Date: _____

Medical History

Child's Name: _____ Today's Date: _____

Were there any difficulties during pregnancy, delivery, or first year of life? (Including premature birth) Yes No

If yes, please explain: _____

Who is your child's Physician? _____ Physicians phone number: _____

Is a physician treating your child for a specific illness? Yes No Please explain: _____

Has your child taken medications in the past? Yes No Please list: _____

Is your child currently taking any medications? Yes No If yes, please list: _____

Has your child ever been hospitalized? Yes No If yes, please explain: _____

Has your child ever had surgery? Yes No If yes, please explain: _____

Was general anesthesia used? Yes No explain any complications: _____

Does your child have any allergies? Yes No if yes, please list: _____

Is your child allergic to latex? Yes No Are your child's immunizations up to date? Yes No

Has your child had any of these occurrences or been diagnosed with any of these conditions?

	Yes	No		Yes	No		Yes	No
Aids/HIV			Chronic Headaches			Heart Murmur		
Anemia			Chronic Ear Infections			Hemophilia		
Asthma			Cleft Lip/Palate			Hepatitis /Liver Disease		
Autism			Congenital Heart Disease			Hyperactivity		
Bladder Condition			Developmental Delay			Kidney Disease		
Blood Transfusion			Diabetes			Leukemia		
Birth Defect			Emotional Disturbances			Mental Retardation		
Bone/Joint Issues			Epilepsy/Seizure			Nutritional Deficiency		
Brain Injury			Eye Problems			Oral Ulcers		
Bruising Easily			Excessive Bleeding			Orthopedic		
Cancer			Excessive Gagging			Rheumatic Fever		
Cerebral Palsy			Fainting/Dizziness			Scoliosis		
Child Abuse			Growth Issues			Sickle Cell Anemia		
Chronic Tonsillitis/Adenoid			Hearing/Speech Problems			Tuberculosis		

Dental History

Child's name: _____ Date of Birth: _____

Has your child been to the dentist before?.....Yes No

1. When was his/her last visit to the dentist? _____
Were x-rays taken at his/her last visit.....Yes No
2. Has your child had any cavities in the past..... Yes No
3. Has he/she had any problems with dental treatment in the past? Yes No
4. Has your child had a negative dental experience in the past? Yes No
5. Has he/she ever had sealants placed by a dentist? Yes No
6. How often does your child eat/drink sweets? (Candy, Soda, Cookie, Juice)
 Rarely Once a day Frequently
7. How many times a day does your child brush his/her teeth? _____
8. When does your child brush his/her teeth?
 Morning After eating any food After meals Before going to bed
9. Does your child have bad breath? Yes No
10. Please check any of the following habits your child has:
 Thumb or Finger sucker Lip sucking or biting Pacifier
 Mouth breathing Bottle in bed Grinding
11. Has he/she ever experienced any dental injuries? Yes No if yes please describe,

12. What is most important to you about your child's dentist and dental care?

13. Do you or your child have any concerns about his/her teeth? _____

I hereby give my permission to Treasured Teeth to provide dental treatment for my child that the doctor deems necessary and appropriate. Routine treatment may include, but may not be limited to: cleanings, x-rays, fluoride, topical and local anesthetic (injections), nitrous oxide etc.

Signature of legal guardian: _____ Date: _____