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)

- ☐ Mailer
- ☐ Social Media
- ☐ Internet Search (Google, Yelp, Website, etc)
- ☐ Insurance Provider
- ☐ Referred by a Patient: ________________________________
- ☐ Magazine/Phonebook: __________________
- ☐ Referred by a Medical/Dental office: __________________
- ☐ 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)____

____

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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 303-853-9955. 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 [ ]

<u>Has your child had any of these occurrences or been diagnosed with any of these conditions?</u>

	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: _________________________