ALONSO
FAMILY DENTAL

CHILD PATIENT REGISTRATION AND MEDICAL/DENTAL HISTORY

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1. Tell Us About Your Child

Today's Date _____

Child's Full Name _____

Nick Name _____ ❒ Male ❒ Female

Child's Birthdate ____ / ____ / ____ Child's Age _____

School _____ Grade Level _____

Home Phone _____ SS# _____

Email _____

Home Address _____ Apt. # _____

City _____ State _____ Zip _____

2. Who Is Accompanying This Child Today?

Name _____ Relation _____

Do you have legal custody of this child? ❒ Yes ❒ No

Legal Guardian's Marital Status? ❒ Single ❒ Widowed ❒ Partnered ❒ Married ❒ Divorced ❒ Separated

Whom may we thank for referring you? _____

Previous Dentist _____

Last Visit Date _____

3. Parent/Guardian Information

Mother's Name _____ Birthdate ____ / ____ / ____

Home Phone _____ Work Phone _____

Employer _____

SS# _____ DL# _____

Father's Name _____ Birthdate ____ / ____ / ____

Home Phone _____ Work Phone _____

Employer _____

SS# _____ DL# _____

4. Person Responsible for Account

Name _____ Relation _____

Billing Address _____

City _____ State _____ Zip _____

Home Phone _____ DL# _____

Employer _____

Work Phone _____ SS# _____

Person Responsible for Making Appointments

Name _____

Home Phone _____ Work Phone _____

5. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group# _____ Policy# _____

Policy Owner's Name _____

Relationship to Patient _____ Birthdate ____ / ____ / ____

Policy Owner's Employer _____ SS# _____

Employer's Address _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group# _____ Policy# _____

Policy Owner's Name _____

Relationship to Patient _____ Birthdate ____ / ____ / ____

Policy Owner's Employer _____ SS# _____

Employer's Address _____

6. What Is The Purpose for Your Visit Today?

_____

_____

Has the child ever had a serious/difficult problem associated with previous dental work? ❒ Yes ❒ No

Is the child's water fluoridated? ❒ Yes ❒ No

Is the child taking fluoridated supplements? ❒ Yes ❒ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❒ Yes ❒ No

Does the child brush his/her teeth daily? ❒ Yes ❒ No

Floss his/her teeth daily? ❒ Yes ❒ No

Child's Physician _____

Date of Last Visit _____

Physician's Phone _____

Is the child currently under the care of a physician? ❒ Yes ❒ No

Please describe the child's current physical health: ❒ Good ❒ Fair ❒ Poor

Has your child ever taken Phen-Fen? (Also known as Redux or Pondimin)? ❒ Yes ❒ No

(Also known as Redux or Pondimin)? If so, when? _____

Please list all drugs that the child is currently taking: _____

_____

Please list all drugs/materials that the child is allergic to: _____

_____

7. Has the Child Ever Had Any of the Following Medical Problems?

Abnormal bleeding	❒ Yes ❒ No
ADD/ADHD	❒ Yes ❒ No
Allergies to any drugs	❒ Yes ❒ No
Any hospital stays	❒ Yes ❒ No
Any operations	❒ Yes ❒ No
Artificial bones/joints/valves	❒ Yes ❒ No
Asthma	❒ Yes ❒ No
Cancer	❒ Yes ❒ No
Congenital heart defect	❒ Yes ❒ No
Convulsions/epilepsy	❒ Yes ❒ No
Diabetes	❒ Yes ❒ No
Handicaps	❒ Yes ❒ No
Hearing impairment	❒ Yes ❒ No
Heart murmur	❒ Yes ❒ No
Hemophilia	❒ Yes ❒ No
Hepatitis	❒ Yes ❒ No
HIV+/AIDS	❒ Yes ❒ No
Kidney/liver problems	❒ Yes ❒ No
Rheumatic/scarlet fever	❒ Yes ❒ No
Sickle cell disease/traits	❒ Yes ❒ No
Tuberculosis (TB)	❒ Yes ❒ No

Please discuss any serious medical problems that the child has had: _____

_____

8. Does/Did the Child Have Any of the Following Habits?

Lip sucking/biting	❒ Yes ❒ No
Nail biting	❒ Yes ❒ No
Nursing bottle habits	❒ Yes ❒ No
Thumb/finger sucking	❒ Yes ❒ No

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

9. Emergency Contact

Name _____ Relation _____

Home Phone _____ Cell Phone _____

Address _____

City _____ State _____ Zip _____

10. Authorization and Consent

It will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need.

Signature of Parent or Guardian _____

Date _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials: _____

Date: _____

DOCTOR'S COMMENTS: _____

_____

_____

_____

_____

MEDICAL HISTORY UPDATE

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

ALONSO
FAMILY DENTAL

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ALONSO FAMILY DENTAL FINANCIAL POLICY

This is an agreement between Dr. Alonso's dental practice, and the Patient/Debtor named on this form.

In this agreement, the words "you," "your" and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we" and "us" refer to Dr. Alonso Family Dental.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, and new charges to the account, and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten (10) days.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of services.

Payment Options (if you have NO insurance)

Payment options - if you have NO insurance:

A. You choose to pay by ___ cash, ___ check, or ___ credit card on the day that treatment is rendered.
B. On treatment involving laboratory fees (crown, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and balance on completion or delivery date.
C. On extensive treatment, you may prefer to secure a bank, credit union or other third-party financing for the entire amount and make payments to the lending institution.
D. We offer special financing through outside financing.

Payment Options (if you have insurance)

Payment options - if you have insurance:

Your dental benefit program is a contract between you, your employer and the insurance company. As a courtesy to you, we will file your claims for you. You are responsible to us for any amount the insurance does not cover.

A. You choose to pay your deductible and any out-of-pocket portions at the time services are rendered by ___ cash, ___ check, or ___ credit card.
B. You choose to pay all of your treatment by ___ cash, ___ check, or ___

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parents responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parents.

Transferring Your Records: You will need to request in writing and pay a reasonable copying fee of $15 if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization with us, you authorize us to receive all relevant information.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein will be in full force and effect.

Patient's Name: _____

Responsible Party (if not the patient): _____

Signature: _____ Date: _____