

LLOYD B. AUSTIN, D.D.S., LTD.
PEDIATRIC DENTIST
For Children, Teens and the Handicapped

CHILD REGISTRATION AND HEALTH HISTORY

NAME OF CHILD _____ BORN _____ AGE _____
Last First Initial Month Day Year

MALE FEMALE

NICKNAME _____

SOC. SEC. # _____

Is this child's first visit to a dentist? _____

If not, when was last visit? _____

1. Is your child presently under the care of a physician for any medical problem? YES NO
 What?
2. Is your child currently taking medication, including birth control? What?
3. Has your child ever been hospitalized or had surgery? For what?
4. Is your child allergic to any food or medicine? What?
5. Any mouth habits, thumbsucking, etc.?
6. Are there any other children in family _____? If so, how many _____

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH ANY PHYSICAL, MENTAL OR EMOTIONAL CONDITION? WHAT?

- | | | |
|--|--|---|
| <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma or chronic respiratory condition</p> <p><input type="checkbox"/> <input type="checkbox"/> Drug Sensitivities</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart trouble or murmurs</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood disorders</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Allergies</p> <p><input type="checkbox"/> <input type="checkbox"/> Brain Injury</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleep apnea (stops breathing)</p> <p><input type="checkbox"/> <input type="checkbox"/> Premature birth</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> HIV (AIDS)</p> | <p>Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures/ Convulsion</p> <p><input type="checkbox"/> <input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney/Liver involvement</p> <p><input type="checkbox"/> <input type="checkbox"/> Bleeding problems</p> |
|--|--|---|

PARENTS COMMENTS _____

LEGAL GUARDIAN OR _____
 FATHER'S NAME _____
 ADDRESS _____
 CITY, STATE ZIP _____
 EMPLOYER _____
 OCCUPATION _____
 HOME PHONE _____ BUSINESS _____
 SOCIAL SECURITY NUMBER _____
 BIRTHDATE: _____

LEGAL GUARDIAN OR _____
 MOTHER'S NAME _____
 ADDRESS _____
 CITY, STATE ZIP _____
 EMPLOYER _____
 OCCUPATION _____
 HOME PHONE _____ BUSINESS _____
 SOCIAL SECURITY NUMBER _____
 BIRTHDATE: _____

Whom may we thank for referring you? _____
 Is your dental work covered by insurance? Yes No. If yes please complete insurance information.

INSURANCE INFORMATION:											
EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST	RELATIONSHIP TO EMPLOYEE			SEX M F	PATIENT BIRTHDATE			EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE BIRTHDATE		
	SELF	SPOUSE	CHILD OTHER		MO.	DAY	YEAR		MO.	DAY	YEAR
EMPLOYER (COMPANY) NAME AND ADDRESS				DENTAL PLAN NAME			UNION LOCAL	GROUP NO.	NAME AND ADDRESS OR CARRIER		

DUAL COVERAGE INFORMATION:											
EMPLOYEE/SUBSCRIBER NAME FIRST MIDDLE LAST	RELATIONSHIP TO EMPLOYEE			EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE BIRTHDATE						
	SELF	SPOUSE	CHILD OTHER		MO.	DAY	YEAR				
EMPLOYER (COMPANY) NAME AND ADDRESS				DENTAL PLAN NAME			UNION LOCAL	GROUP NO.	NAME AND ADDRESS OR CARRIER		

Can you be available for short notice appointments should we have an unexpected opening? Yes No

Which days? _____ What times? _____

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT.

 SIGNED (PATIENT, PARENT IF MINOR) _____ DATE _____
 I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

 SIGNED (INSURED PERSON) _____ DATE _____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

We charge a 1½% monthly finance charge on all accounts with a balance 60 day old.

Payment is due in full at each appointment. For your convenience, we offer the following methods of payment. Please check the option you prefer.

_____ CASH _____ PERSONAL CHECK _____ INSURANCE CO-PAY

_____ CREDIT CARD (VISA, MC., AMEX, DISC)

A COPY OF THE OFFICE CREDIT POLICY IS AVAILABLE AT THE FRONT DESK UPON REQUEST.

Our practice is 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 in full regardless of any insurance company's arbitrary determination of usual and customary rates. Thank you for your cooperation. If there is any other information of any kind which you feel would be of value to us in your dental treatment, please add such information.

I authorize treatment of the child. I agree to pay all fees and charges for such treatment.

SIGNATURE _____ Date _____

Financial arrangements for dental treatment can be made with our office prior to the commencement of treatment. As a courtesy to our patients, we will be happy to complete and file insurance forms relative to dental treatment. However our professional services are rendered to you, not to the insurance company. Our fees for services are the same for all patients, whether or not they have a dental insurance program. Your particular program may base its allowance on a fee schedule which may or may not coincide with our office fees. **PLEASE REMEMBER THE FINANCIAL OBLIGATION FOR DENTAL TREATMENT IS BETWEEN YOU AND THIS OFFICE AND IS NOT DEPENDENT UPON INSURANCE.**

AUTHORIZATION AND RELEASE:

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYERS AND/OR OTHER HEALTH PRACTITIONERS.

I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

I AUTHORIZE AND REQUEST MY DENTIST TO USE *SIGNATURE ON FILE* FOR MY SIGNATURE ON ALL DENTAL INSURANCE FORMS TO EXPEDITE COMPUTER PROCESSING OF MY CLAIMS.

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

IF I DO NOT PAY THE ENTIRE BALANCE WITHIN 60 DAYS OF THE MONTHLY BILLING DATE, A LATE CHARGE OF 1.5% ON THE BALANCE THEN UNPAID AND OWED WILL BE ASSESSED EACH MONTH. I REALIZE THAT FAILURE TO KEEP THIS ACCOUNT CURRENT MAY RESULT IN YOU BEING UNABLE TO PROVIDE ADDITIONAL DENTAL SERVICES, EXCEPT FOR DENTAL EMERGENCIES OR WHERE THERE IS PREPAYMENT FOR ADDITIONAL SERVICES. IN THE CASE OF DEFAULT ON PAYMENT OF THIS ACCOUNT, I AGREE TO PAY COLLECTION COSTS AND REASONABLE ATTORNEY FEES INCURRED IN ATTEMPTING TO COLLECT ON THIS ACCOUNT OR ANY FUTURE OUTSTANDING ACCOUNT BALANCES.

PARENTS WHO WISH TO BE WITH THEIR CHILD DURING TREATMENT MUST FIRST CONFER WITH ONE OF THE DOCTORS. WE WILL TREAT YOUR CHILD AS WE WOULD OUR OWN.

X _____
SIGNATURE OF PARENT OR GUARDIAN OF MINOR DATE

REVIEWED BY: DATE _____
STAFF MEMBER'S SIGNATURE _____