CHILD REGISTRATION

DATE _____

Patient Name _____ Nickname _____

Mailing Address _____

Street Address (if different) _____

Telephone _____ Birthdate _____ SS # _____

Mother _____ Telephone (if different) _____

Mother's Address (if different) _____

Mother's employer _____ Work Phone _____

Father _____ Telephone (if different) _____

Father's Address (if different) _____

Father's Employer _____ Work Phone _____

Child's School _____

Interests & Hobbies _____

Is this your child's first dental experience? _____ Yes _____ No

What is your child's attitude toward this visit? _____

_____

Who may we thank for referring you to our office? _____

In case of an emergency, please list the name of a friend or relative whose telephone number is different than yours.

Name _____ Relationship _____

Address _____ Telephone _____

DENTAL INSURANCE INFORMATION

Insurance # 1

Policyholder _____ Birthdate _____

Employer _____ SS # _____

Insurance Company Name _____

Policy # _____ Group # _____

Insurance # 2

Policyholder _____ Birthdate _____

Employer _____ SS# _____

Insurance Company Name _____

Policy # _____ Group # _____

Our office policy is to accept payment at the time services are rendered unless arrangements are made in the front office in advance. We file your dental insurance as a courtesy to you. You are ultimately responsible for payment for all dental care.

I authorize the release of any informtion necessary to process my insurance claim.

X _____

(over please)

CHILD'S HEALTH HISTORY

Child's Physician _____ **Address** _____ **Phone** _____

Date of last physical examination _____ **Results** _____

Date of last visit to a dentist _____

For what service _____

	Yes	No
Has child complained about dental problems ___	❑	❑
Any unhappy dental experiences _____	❑	❑
Any injuries to mouth-teeth-head _____	❑	❑
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etcs. ___	❑	❑
Any unusual speech habits _____	❑	❑
Any lost teeth _____	❑	❑
Have missing teeth been replaced _____	❑	❑
Orthodontic appliances worn now or ever been __	❑	❑
Does your child brush teeth daily _____	❑	❑
Do you assist child with tooth brushing _____	❑	❑
How often _____		
Is dental floss used _____	❑	❑
How often _____		
Is flouride taken in any form _____	❑	❑
Child's attitude to dentistry _____		

	Yes	No
Is child under care of physician now _____	❑	❑
Is child receiving any medication or drugs _____	❑	❑
Is there any excessive bleeding when cut _____	❑	❑
Has child ever been hospitalized _____	❑	❑
Has child ever had surgery _____	❑	❑
Is there any allergy to penicillin or other drugs___	❑	❑
Are there other allergies: food - pollen - animals - dust - other _____	❑	❑
Does child have good physical coordination ____	❑	❑
Are there any emotional problems _____	❑	❑

Summary (for doctor's use) _____

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

___Anemia	___Chronic Sinus	___Hearing	___Mastoid	___Thyroid
___Asthma	___Convulsions	___Heart	___Measles	___Tuberculosis
___Bladder	___Diabetes	___Kidney	___Mononucleosis	___Other
___Cerebral Palsy	___Epilepsy	___Liver	___Mumps	
___Chicken Pox	___Fainting	___Malignancies	___Rheumatic Fever	

SUMMARY: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

	Yes	No
May we request release of your child's medical records for our reference _____	❑	❑

This information was discussed with and given by _____

Relation to Child _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this day _____ of _____, 20___.

Print Patient Name: _____

Relationship to patient (if applicable): _____

Signature: _____

Bryan T. Stump, DMD – Family Dentistry
1642 US 131 South
Petoskey, MI 49770

Payment Policy

Insurance Acceptance Guidelines:
The following is a list of insurance companies we are in Network (participate) with:
Cigna & Delta Dental both include Medicare Advantage plans.

We are out of network with all other insurances. As a courtesy to the patient we will bill all insurance policies that are out of network.

The patient is responsible for all co-insurance and deductibles.

All self-pay patients are expected to pay date of service.

Unpaid balances:

Any unpaid balances on your account past 90 days (from the time insurance pays) will result in a monthly finance charge of 1.5% of your total balance until balance is paid in full.

We can take credit/debit card payments over the phone.

No Show Appointments:

1st missed/no show appointment- No charge, we understand life happens.
2nd missed/no show appointment- $35 non reimbursable charge.

We classify a missed/no show appointment as being an appointment where there is not enough time to fill the appointment with another patient in need of services. If we are able to fill your appointment no charge will be filed. A 5-minute notice is not enough time to fill your appointment.

We give a courtesy call within 48 hours to all of our patients personally, leave messages to confirm, and you most likely have an appointment card. **Please call us back to confirm your appointment!** If you think you have an appointment but did not receive a phone call within 48 hours of this appointment please call us.

Please sign this form below to acknowledge that you have read over all of our policies.
Thank you!

_____ _____
Patient Signature/Parent or Guardian Signature Date

_____
Patient Printed Full Name

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