Welcome to Mountain Valley Kids Dental!

REGISTRATION FORM

Section I: Patient Information Date_____

Child's Name:_____ I prefer to be called: _____
Address:_____City:_____State:_____Zip_____
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Male ☐ Female
If Student, Name of School_____ City/State_____
Whom may we thank for referring you? _____
Person to contact in case of emergency_____ Phone_____

Section II Responsible Party

Relationship to Patient: ☐ Father ☐ Mother ☐ Grandparent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____
Home Phone (_____)_____ Cell Phone (_____)_____
The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Employer_____ Work Phone (_____) _____ SSN#_____
Email Address_____ Would you like to receive our e-newsletter? ☐ Yes ☐ No

Section III Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

---------- DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ----------

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Patient Name:_____

Dental History

Please check the following problems that apply:

- Sensitivity (hot, cold, sweet) ☐
- Headaches, Earaches, Neck Pain ☐
- Jaw Joint Pain ☐
- Teeth or Fillings Breaking ☐
- Grinding or Clenching Teeth ☐
- Bleeding, Swollen or Irritated Gums ☐
- Loose, Tipped or Shifting Teeth ☐
- Bad Breath ☐
- Thumb/Finger Sucking ☐
- Fingernail Biting ☐
- Lip or Cheek Biting ☐

Has your child had any of the following:

- Braces ☐
- Periodontal (gum) treatments ☐

On a scale of 1-10, with 10 being the highest rating:

- How important is your child's health to you?
  1 2 3 4 5 6 7 8 9 10
- Where would you rate your child's current dental health?
  1 2 3 4 5 6 7 8 9 10
- Where do you want your child's dental health to be?
  1 2 3 4 5 6 7 8 9 10

Name of previous Dentist:
City _____State _____
Phone Number _____

Please share the following dates:

- Last Cleaning _____
- Last Oral Cancer Screening _____
- Last X-Rays _____

Medical History

☐ AIDS/HIV	☐ Drug Addiction	☐ HIV Positive	☐ Seizures/Epilepsy
☐ Allergies (seasonal)	☐ Emphysema	☐ Jaundice	☐ Sleep Apnea
☐ Anemia	☐ Excessive Bleeding	☐ Jaw Joint Pain	☐ Snoring
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Stomach Problems
☐ Artificial Heart Valve	☐ Glaucoma	☐ Liver Disease	☐ Stroke
☐ Artificial Joints	☐ Heart Conditions	☐ Low Blood Pressure	☐ Thyroid Disease
☐ Asthma	☐ Heart Lesions (congenital)	☐ Mitral Valve Prolapse	☐ Tonsillitis
☐ Blood Disease	☐ Heart Murmur	☐ Pregnant Currently	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Surgery	☐ Radiation (head/neck)	☐ Ulcers
☐ Cancer	☐ Hepatitis A	☐ Respiratory Problems	☐ Venereal Diseases
☐ Chemotherapy	☐ Hepatitis B	☐ Rheumatic Fever	☐ Other _____
☐ Diabetes	☐ Hepatitis C	☐ Rheumatism	_____
☐ Dizziness	☐ High Blood Pressure	☐ Scarlet Fever	_____

Does your child have any of the following drug allergies:

☐ Aspirin	☐ Valium
☐ Nitrous Oxide	☐ Penicillin
☐ Local Anesthetic	☐ Sulfa
☐ Codeine	☐ Other

Is your child under a physician's care? What for?
_____

Is your child taking any medications? What type?
_____

Pediatrician/Physician_____ **Phone #**_____

Parent/Guardian Signature:_____ **Date:** _____

Mountain Valley Kids Dental

Appointment Policy

We understand that your time is valuable. You can expect us to see you at the appointed time and to keep your time spent in our office as short as possible. In return, when you make an appointment with us please be on time as we have reserved our time just for your child. Please make every effort not to change your scheduled appointment. If you are unable to make your appointment, please provide us at least 24 hours advanced notification. Short cancellations (less than 24 hours) or missed appointments are subject to a $50.00 cancellation fee. Patients who habitually miss or cancel appointments may be dismissed from the practice.

We make every effort to keep precisely to our daily schedule but we will adjust the schedule when a patient arrives in pain or when a treatment takes more time than expected. We appreciate your understanding and cooperation. If circumstances require dramatic changes to the schedule, we will do our best to notify you as far in advance as possible.

Financial Policy

Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. Unless another financial option is pre-arranged, payment in full is due the day of treatment. Should a patient have dental insurance with assignment to Mountain Valley Kids Dental, the estimated patient portion will be the amount due, and any applicable deductibles will also be collected. Insurance payments without assignment will be sent to the insured with payment due in full on the date of service.

We must emphasize that as dental care providers our relationship is with you, not your insurance company. While the filling of insurance claims and checking on your benefits is a service that we extend to our patients, all charges are your responsibility from the date services are rendered. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. You are responsible for any payment discrepancy that your insurance company may fail to pay due to the terms of your contract with them. If payment is not received within 30 days of the statement date, a late charge of 2.5% will be added to the account balance of each month.

**We accept most major credit cards, cash, and check for payment. We also offer CareCredit. **

Authorization and Consent

General Consent to Treatment – I agree and consent to dental examinations by licensed dental professionals at Mountain Valley Kids Dental. I understand that additional diagnostic procedures and dental treatments may be recommended and will be discussed with me prior to such treatment being rendered. All treatment will be rendered by qualified dental personnel in accordance with governing healthcare laws. I acknowledge that there are no guarantees, expressed or implied, as to the results of any procedures or dental treatments performed.

Release of Information – I authorize Mountain Valley Kids Dental to release any information regarding my dental/medical history, diagnosis or treatment to third-party payors and/or other health professionals as required.

Assignment of Insurance Benefits – I authorize and request my insurance company to pay my benefits directly to Mountain Valley Kids Dental**.**

Office Policies- I acknowledge and agree to the Appointments Policy and Financial Policy. I hereby acknowledge the receipt of a copy of the practice's HIPAA Privacy Policies and Procedures. I understand I may ask any questions regarding these policies.

_____ _____

Signature of Patient, Parent, or Guardian Date

_____ _____

Please PRINT name of Patient Relationship to Patient