CHILD REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

DATE			
NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE NO.			
BIRTH DATE	AGE	MALE	FEMALE
SCHOOL		GRADE	
SOCIAL SECURITY NO.			

ACCOUNT INFORMATION			
PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT			
NAME			
RELATIONSHIP TO PATIENT			
ADDRESS			
CITY	STATE	ZIP	
PHONE NO.			
MOM			
NAME			
EMPLOYER			
BUSINESS PHONE NO.		EXT.	
CELL			
EMAIL			
DRIVERS LICENSE #			
DAD			
NAME			
EMPLOYER			
BUSINESS PHONE NO.		EXT.	
CELL			
EMAIL			
DRIVERS LICENSE #			

DENTAL INSURANCE	
PRIMARY CARRIER	
INSURANCE	
GROUP NO.	
ID NUMBER	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYER	
EMPLOYEE SOCIAL SECURITY NO.	
SECONDARY CARRIER	
INSURANCE COMPANY	
GROUP NO.	
ID NUMBER	
DATE OF BIRTH	DATE EMPLOYED
EMPLOYER	
EMPLOYEE SOCIAL SECURITY NO.	

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?		
NAME:	RELATIONSHIP:	
REFERRED TO US BY		
PERSON TO CONTACT FOR EMERGENCY		
PHONE NUMBER		
ADDRESS		
CITY	STATE	ZIP

Please turn over and sign

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____ dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. We are also committed to providing you up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative cost.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and the insurance company. We are considered an out-of-network provider. Dr. Michael Morris is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you, we will help you process all of your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring proof of insurance to each appointment.

All co-payments are due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Outside financing is available through CareCredit upon request and approval.

There will be a $25.00 service charge on all returned checks. Any unpaid balances older than 60 days may be subject to a 1.5% monthly finance charge. Accounts over 90 days without prior financial arrangements will be considered delinquent and subject to our Collection Agency.

We make every effort to honor your reserved time and ask that you extend the same courtesy to us. If you cannot keep your reserved appointment time, we require 48 hours notice (2 business days) to avoid a charge for lost appointment time.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

_____

Print Name

_____ _____

Signature of Patient/Legal Guardian Date