MILLHOPPER PEDIATRIC DENTISTRY, PL

PATIENT REGISTRATION and APPLICATION FOR TREATMENT

Please print and complete all applicable sections

PATIENT

Last Name | First | Middle Initial | Date of Birth | Sex

Mailing Street Address | City | State/Zip Code

Home Telephone Number | Social Security Number

RESPONSIBLE PARTY

Last Name | First | Middle Initial | Relationship

Mailing Street Address | City | State/Zip Code | Home Telephone #

Cell/Alternate Telephone # | E-Mail Address

Employed by | Address | Work Telephone #

EMERGENCY CONTACT

Last Name | First | Middle Initial | Relationship

Street Address | City | State/Zip Code | Daytime Telephone #

Patient's Physician | Office Telephone #

DENTAL INSURANCE

Name of Insured | Relationship to Patient | Date of Birth | Sex

Insurance Company Name | Company Providing Insurance

Contract Number | Group Number | Social Security Number of Insured

How did you hear about us?_____

Financial Policy

Payment for service is due at the time services are rendered. We accept cash, personal checks, Visa and MasterCard. Returned checks are subject to $75 service charge and you will lose your privilege to write checks in our office. There will be a monthly re-billing fee added to any accounts which have an outstanding balance after 30 days. This does not include accounts with pending insurance claims. We will gladly discuss the proposed treatment and do our best to answer any

questions relating to your insurance. However, your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. We must emphasize that as your (child's) dental care provider, our relationship and concern is with your (child's) health, not the insurance company. All charges are your responsibility from the date services are rendered. You will be responsible for payment on any account balance after 60 days, including those that insurance has not paid, or collection action may be taken. You will be responsible for all collection/attorney fees. We realize that emergencies do arise and may affect timely payment on your account. If such extreme cases do occur, please contact us promptly for assistance in the management of your account.

Cancellation

As a courtesy we call to confirm your appointment yet we may not always reach you when we call. We ask that you give 48-hour advance notice when cancelling an appointment. If no notice is given, your account will be charged $30.

We appreciate you choosing our service. We realize your time is valuable. In an effort to minimize the waiting time and to effectively utilize the treatment time so that we can provide the best treatment for your child, we have set up the following guidelines for this office:

- Parent/guardian shall accompany the patient to the scheduled appointment.
- Parent/guardian of the patient shall remain in the waiting room while the patient is being treated.
- Routine dental care includes an exam and cleaning at least every six months. The patient's treatment plan shall be completed in a timely manner and all scheduled appointments shall be kept.

We reserve the right to refer any patient whose needs may be better met through another provider and to refuse dental service to any patient who is late, does not keep appointments, or who does not abide by the above guidelines.

I, being the parent or guardian of _____ hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures may be deemed necessary during treatment. I understand that Dr. Beaufait and such assistants as she may designate to treat the above-mentioned patient will use restorative, oral surgery, and patient management techniques that are reasonable, necessary and advisable. I also authorize the administration of anesthetics or analgesics, which may be deemed advisable by Dr. Beaufait.

The treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above-named patient.

All patient records and radiographs are the sole property of MPD and I understand are taken for purposes of diagnosis. If I am referred to or elect to seek treatment by another dentist, any pertinent record/radiographs will be copied for a $30.00 duplication fee payable by me. Copies of records/radiographs will not be released by MPD unless requested in writing.

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I have read and agree to the above statements. I also have received a copy of the office's **NOTICE OF PRIVACY PRACTICES.**

_____

Signature Print Name Date

**********_For Office Use Only_**********

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communication barrier prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement
( ) Other (Please specify) _____