Children's Dental Clinic
of Las Cruces

Health History and Registration

PATIENT INFORMATION

NAME: LAST_____FIRST_____MI_____SEX: M F

BIRTH DATE: _____/_____/_____AGE: _____SS#_____-_____-_____

ADDRESS _____CITY_____

STATE _____ ZIP _____ HOME PHONE _____ CELL _____

OTHER_____EMAIL_____

How did you hear about our office?_____

HEAD OF HOUSEHOLD

NAME: LAST_____FIRST_____MI_____ SEX: M F

BIRTH DATE: _____/_____/_____ AGE: _____ SS#_____-_____-_____ MARITAL STATUS: S M W D

ADDRESS _____CITY_____

STATE _____ZIP _____ HOME PHONE _____WORK _____

CELL _____ EMPLOYER_____

NUMBER OF YEARS EMPLOYED: _____RELATIONSHIP TO PATIENT_____

SPOUSE/OTHER PARENT INFORMATION: NAME_____EMPLOYER _____

OCCUPATION_____SS# _____-_____-_____BIRTH DATE _____/_____/_____

WORK PHONE _____ CELL PHONE _____

EMERGENCY CONTACT

RELATIVE NOT LIVING WITH YOU: _____RELATIONSHIP: _____

ADDRESS_____CITY_____STATE _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

DENTAL INSURANCE INFORMATION

INSURANCE CO. NAME _____INSURANCE CO. PHONE _____

STATE_____ZIP_____GROUP # _____HOLDERS NAME_____

SECONDARY INSURANCE CO. NAME _____INSURANCE PHONE _____

STATE_____ZIP_____GROUP # _____ HOLDERS NAME_____

IT IS IMPORTANT THAT THE MEDICAL AND DENTAL INFORMATION PROVIDED IS CURRENT AND ACCURATE. FOR OUR DOCTORS TO PROVIDE SAFE AND EFFECTIVE DENTAL CARE, IT IS NECESSARY FOR THEM TO KNOW YOUR MEDICAL AND DENTAL HISTORY. THANK YOU FOR TAKING YOUR TIME TO FILL OUT THIS FORM COMPLETELY.

DENTAL HISTORY

NAME OF PREVIOUS DENTIST_____PHONE_____

HOW LONG HAS IT BEEN SINCE YOU'VE SEEN A DENTIST? _____ DATE OF LAST X-RAYS_____

REASON FOR YOUR DENTAL VISIT TODAY_____

HAVE YOU HAD ANY PERIODONTAL (GUM) PROBLEMS? YES NO

DO YOUR GUMS BLEED OR FEEL IRRITATED OR TENDER? YES NO

DO YOU FLOSS REGULARLY? YES NO

ARE YOUR TEETH SENSITIVE TO (PLEASE CIRCLE) HOT COLD SWEETS PRESSURE

DO YOU HAVE HEADACHES, EARACHES, OR NECK PAIN? YES NO

HAVE YOU WORN BRACES ON YOUR TEETH? YES NO

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? YES NO

IF NOT, PLEASE EXPLAIN_____

MEDICAL HISTORY

PHYSICIANS NAME_____ PHONE #_____

ARE YOU CURRENTLY UNDER A PHYSCIANS CARE? YES NO IF SO, FOR WHAT? _____

WHAT MEDICATIONS ARE YOU CURRENTLY TAKING? _____

_____

DO YOU USE ANY TYPE OF TOBACCO PRODUCTS? YES NO IF SO, WHAT?_____

(FOR WOMEN ONLY) ARE YOU PREGNANT? YES NO IF NOT, ARE YOU NURSING? YES NO

PLEASE CHECK ANY OF THE FOLLOWING THAT YOU HAVE OR HAVE HAD IN THE PAST:

- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Heart Valve
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Diabetes
- ❑ Dizziness
- ❑ Drug Abuse
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Growths
- ❑ Hay Fever
- ❑ Head injuries
- ❑ Heart Disease
- ❑ Heart murmur
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV/AIDS positive
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Pain in jaw joints
- ❑ Pregnancy
- ❑ Psychiatric care
- ❑ Radiation treatment
- ❑ Respiratory Problems
- ❑ Rheumatic/Scarlet fever
- ❑ Rheumatism
- ❑ Seizures
- ❑ Sinus problems
- ❑ Smoking
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease

ARE YOU ALLERGIC OR HAVE YOU EVER REACTED ADVERSELY TO ANY OF THE FOLLOWING:

- ❑ Aspirin
- ❑ Latex
- ❑ Codeine
- ❑ Sulfa
- ❑ Local Anesthetic
- ❑ Nitrous Oxide
- ❑ Ibuprofen
- ❑ Erythromycin
- ❑ Penicillin
- ❑ Tetracycline
- ❑ Other_____

_____

CONSENT

PATIENT / RESPONSIBLE PARTY SIGNATURE:_____DATE:_____

OFFICE POLICIES

Welcome to our practice and thank you for choosing us as your dental care providers. We are committed to your treatment being successful. All patients must complete and sign our information/new patient form prior to any treatment. We ask that you please read the following office policies to familiarize yourself with our office. After reading, please sign below. Thank You.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Estimates for major dental care are available. A monthly financial fee of 18% is applied to balances not paid by the 1st of the following month after treatment. There will be a $35.00 handling fee, in addition to any bank charges for any returned checks. For your convenience we accept cash, checks, Visa, Master Card, American Express and Discover.

REGARDING INSURANCE

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. Your insurance policy is a contract between you and your insurance company. Although we are happy to assist you with your insurance claims, we are not a party to that contract. In the event we do accept assignment of benefits, we require that you pay the deductible (or provide proof that you have done so) and pay the estimated portion of your bill at the time of service. We often accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We are unable to bill your insurance company unless you give us your complete insurance information.

We allow 60 days for your insurance company to pay. In the event your insurance has not paid within a 60-day period, the bill will then be turned over to you and you will be responsible to pay within the next 30 days. At that time we also resubmit to your insurance company for the last time. A simple call to your insurance company for you will greatly facilitate the payment. Remember, payment for your dental bill is always your responsibility. We allow your insurance company 60 days to pay as a service to you. All percentages and deductibles are due in full at the time of treatment.

REMEMBER, WHAT WE COLLECT FROM YOU AT THE TIME OF VISIT IS ONLY AN ESTIMATE. AFTER RECEIVING YOUR INSURANCE PAYMENT, WE WILL BILL OR CREDIT YOUR ACCOUNT THE DIFFERENCE.

USUAL AND CUSTOMARY RATES

OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT FOR OUR PATIENTS AND WE CHARGE WHAT IS USUALLY AND CUSTOMARY FOR OUR AREA. YOU ARE RESPONSIBLE FOR PAYMENTS REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY, OUT-DATED DETERMINATION OF USUAL AND CUSTOMARY RATES.

APPOINTMENTS AND SCHEDULING

PLEASE REMEMBER THAT ONCE YOU MAKE AN APPOINTMENT, THE DOCTOR'S TIME, TREATMENT ROOM, AND SUPPORT PERSONNEL HAVE BEEN RESERVED SPECIFICALLY FOR YOU. WHEN WE SET ASIDE THIS RESERVED APPOINTMENT TIME FOR YOU WE WILL CONSIDER IT AS TIME YOU HAVE COMMITTED. IF YOU FEEL THAT YOU REQUIRE A REMINDER PHONE CALL, PLEASE REQUEST THIS FROM OUR STAFF. **UNLESS CANCELLED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE $25.00 PER REGULAR APPOINTMENT, OR $50 PER SEDATION APPOINTMENT.** IF A MISSED APPOINTMENT DOES OCCUR, WE WOULD ASK YOU TO PAY YOUR MISSED APPOINTMENT FEE PRIOR TO BEING SEEN. IF A SECOND MISSED APPOINTMENT OCCURS, WE ASK THAT YOU PAY YOUR MISSED APPOINTMENT FEE PRIOR TO SCHEDULING YOUR NEXT APPOINTMENT. IF A THIRD MISSED APPOINTMENT OCCURS, WE ASK THAT YOU TAKE THE TIME TO FIND A NEW DENTAL CARE PROVIDER. WHEN PATIENTS FAIL TO ARRIVE FOR THE APPOINTMENTS THEY SCHEDULED, THAT TIME IS LOST WHICH COULD HAVE BEEN USED TO TREAT OTHER PEOPLE IN NEED. PLEASE HELP US SERVE YOU BETTER BY KEEPING THE APPOINTMENTS YOU SCHEDULE.

Your time is valuable to us. We try to stay on schedule and most of the time we do. We ask that you help us to do this by arriving at least 5 minutes prior to your appointment. **In order to keep our office operating on time, it may be necessary to reschedule your appointment if you are more than 10 minutes late.** If uncontrollable circumstances have occurred to make you up to 10 minutes late, there may be a possibility that you may still be seen. However, other patients that are currently scheduled will be seen first. Despite our best intent, treatment emergencies do, on occasion, arise in our schedule causing unavoidable delays. We will apprise you of any such circumstance at the earliest possible opportunity to avoid any inconvenience for you.

MINOR PATIENTS

The parent, adult, or guardian accompanying the child during the child's appointment, is responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, payment by case or check at the time of service. All children must be accompanied by their legal guardian. **If an adult that is not the child's legal guardian is bringing in the child, a signed letter by the legal guardian must be presented at the day of appointment or the child will not be able to be seen.**

NITROUS

Please be aware that we use nitrous oxide for all appointments requiring anesthesia. The majority of insurances DO NOT cover Nitrous Oxide. If for any reason you are not wanting to have this administered to your child, please let the office know before the day of the appointment. The parent or guardian bringing the child to the appointment **MUST** stay in the building the entire length of the appointment.

I HAVE READ THE POLICIES AND I UNDERSTAND AND AGREE TO THEM

NAME (PLEASE PRINT)	SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

H.I.P.A.A.

You may refuse to sign this acknowledgement

I, _____, acknowledge that I have read a copy of Children's Dental Clinic of Las Cruces Notice of Privacy Practices.

_____	_____	_____
Please Print Name	Signature	Date

FOR OFFICIAL USE ONLY

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

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)_____