Child's Registration and History

Child's name:_____Preferred Name:_____
Sex: □Male □Female Date of Birth:___/___/___ Age:_____ School:_____
Is this your child's first dental visit? □Yes □No If no, name of former dentist_____
Approximate Date of last visit:_____Purpose:_____
Do you have any concerns regarding your child's dental health?_____
Has your child had any traumatic dental experiences?_____
Name of Parent's dentist:_____
Please list all brothers and sisters:_____
How did you hear about us?_____
Name of your child's pet:_____Favorite interest:_____Favorite sport:_____

Parental Information

Father's Full Name:_____	Mother's Full Name:_____
SS#:_____	SS#:_____
Date of Birth:_____	Date of Birth:_____
Home Phone:_____	Home Phone:_____
Cell Phone:_____	Cell Phone:_____
Email address:_____	Email address:_____
Address:_____	Address:_____
City:_____State:____Zip:_____	City:_____State:____Zip:_____
Occupation:_____	Occupation:_____
Employer:_____	Employer:_____
Business Phone:_____	Business Phone:_____
Marital Status:	
□Single□Married□Separated□Divorced□Other	□Single□Married□Separated□Divorced□Other

Child lives with: □Both Parents □Mother □Father □Joint Custody □Other Guardian

__Note:__ All office correspondence will go to the address where the child resides. The guardian that accompanies the patient to appointments will be responsible for payment.

Emergency Contact_____Relationship_____Phone_____
It is acceptable to have an emergency contact that resides in another state

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Insurance/Financial Information

Primary Insurance Co.:_____	Secondary Insurance Co.:_____
Subscriber Name:_____	Subscriber Name:_____
Date of Birth:_____	Date of Birth:_____
SS# or ID#:_____	SS# or ID#:_____
Group/Policy#:_____	Group/Policy#:_____
Employer:_____	Employer:_____
Relationship to Patient:_____	Relationship to Patient:_____

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file. I authorize release of information relating to all insurance claims. I hereby authorize payment directly to Dr. Karen Yee-Lo, and/or Dr. John C. Lo.

I understand that my insurance carrier may pay less than the actual bill for services and that the treatment estimates are given as a courtesy but cannot be guaranteed. Estimated payment is to be paid on the date of service unless other arrangements have been made with the office manager.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature_____Date_____

I am not receiving DSHS medical assistance and I agree to pay for services. If I later become eligible for DSHS medical assistance, I agree to notify the provider's billing office. In the case of retro certification, I understand that I will not be reimbursed for services rendered prior to presenting proof of coverage.

Signature_____Date_____