Aesthetic Dental Center

CHILD REGISTRATION FORM

Patient's Name _____ Preferred Name _____

Birthdate _____ Age _____ Gender: □ Male □ Female

Social Security Number _____

Father's Name _____ SS# _____ Birthdate _____

Address _____City _____ State _____ ZIP _____

Phone # _____Cellular phone # _____

Email Address _____

Employer _____ Position _____ How Long? _____

Employer Address _____ Phone # _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Mother's Name _____ SS# _____ Birthdate _____

Address _____City _____ State _____ ZIP _____

Phone # _____ Cellular phone # _____

Email Address _____

Employer _____ Position _____ How Long? _____

Employer Address _____ Phone # _____

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Who should we notify, other than parents, in case of emergency?

Name _____ Relationship _____

Address _____ Phone # _____

City _____ State _____ ZIP _____

Previous Dentist _____ Phone # _____

How did you hear about our office?

□ Phone Book –Dex □ 1-800-DENTIST

□ Phone Book – Hispanic Yellow Pages □ Family Member: _____

□ Insurance □ Doctor's Office: Dr._____

□ Other: (Please specify)_____

Payment Information: ***All services must be paid by cash, check or credit card as each service is provided***. Patients with insurance or other coverage must complete all the required information.

Primary Insurance:
Subscriber's Name _____ SS#_____

Relationship of Patient: □ Self □ Spouse □ Child Birthdate _____

Insurance Company _____ Group# _____

Address _____ Phone _____

_____

Secondary Insurance:
Subscriber's Name _____ SS#_____

Relationship of Patient: □ Self □ Spouse □ Child Birthdate _____

Insurance Company _____ Group# _____

Address _____ Phone _____

_____

AUTHORIZATION FOR RELEASE OF INFORMATION: (All patients/guarantors must sign)
I certify that the above information is correct. I authorize release of any information relating to my dental claims. I understand that I am responsible for all costs of dental treatment. I hereby authorize payment of the group insurance benefits otherwise payable to me directly to Aesthetic Dental Center.

Patient/Guarantor Signature _____ Date _____

PERMISSION FOR TREATMENT: (All patients/guarantors must sign)
I hereby give my permission to Aesthetic Dental Center's dentists to provide dental treatment as deemed necessary.

Patient/Guarantor Signature _____ Date _____

PAYMENT AGREEMENT: (All patients/guarantors must sign)
I understand that my Insurance Policy is between the insurance company and myself and I am liable to Aesthetic Dental Center for services rendered. I also understand I will be furnished with an **estimate** regarding my insurance benefits at the onset of treatment.
I agree to pay Aesthetic Dental Center for all dental treatment at the time of service. I promise to pay my account until my balance has been paid in full. Should my account become past due, I will be charged 1.5% per month interest with $25.00 late charge fee on the overdue amount. I also understand that should my account become delinquent, it may be turned over for collection, including any attorney's fees incurred.

Patient/Guarantor Signature _____ Date _____

Please remember that once an appointment has been made, this time is reserved specifically for you. No charge will be made for rescheduling an appointment, provided early notice of *at least* 2 business days are given. Otherwise a minimum charge of $50 per hour may be incurred. We reserve the right to not reschedule your appointment.