New Patient Application for _____ Date _____

Preferred Name_____ DOB_____ Age_____ Gender: Male / Female

Address_____ City_____ Zip Code_____

Guardian's Name_____ DOB_____ Cell Phone_____

Address _____ Home Phone_____

Email_____ Employer_____ Work Phone_____

Guardian's Name_____ DOB_____ Cell Phone_____

Address _____ Home Phone_____

Email_____Employer_____Work Phone_____

Whom may we thank for referring you to our practice?

□ Another parent (friend) □ Another patient □ Dental Office □ School □ Work □Internet

Name of person or office referring you to our practice: _____

What is the reason for your visit today? _____

Insurance Information

Name of Insured_____ DOB_____ SS#_____

Insurance Carrier Name_____ Insurance Phone _____

Group #_____ Policy or Subscriber ID #_____ Payor ID _____

Health History

□ Yes □ No - Previous health problems?Explain_____

□ Yes □ No - Ever been hospitalized? Explain_____

□ Yes □ No - Food or medicine allergies? List_____

□ Yes □ No - Currently taking any medications? List_____

□ Yes □ No - Were there any problems at birth? Explain_____

□ Yes □ No - Any concerns about jaw joint pain or sounds? (TMJ) Explain_____

Please circle any item that the patient been diagnosed/treated/observed for:

Heart disease/murmur	Asthma	Bleeding/transfusions	Autism
Latex Allergy	Liver/GI Disease	Anemia	Diabetes
Joint Replacement	ADD	ADHD	Asperger's
Down syndrome	Kidney disease	Hepatitis	Mental delays
Epilepsy/Seizures	Cleft lip/palate	Cerebral palsy	Cancer/tumors
HIV/AIDS	Birth defects	Genetic disorder	PDD

Continued on back side

Dental History

□ Yes □ No - Has the patient ever been to the dentist? If yes, name of dentist_____
Date of last dental visit and x-rays_____
□ Yes □ No - Any previous bad experience with a dentist? Explain_____
□ Yes □ No - Any previous injury/trauma? Explain_____
□ Yes □ No - Any concerns about teeth appearance/color? Explain_____
□ Yes □ No - Concerns about cavities, pain, infection? Explain_____
□ Yes □ No - Does your child suck a finger, thumb or pacifier? Explain_____
Have they in the past? What age did they stop? _____
Other concerns _____

Financial Policy

Thank you for choosing our office for you/your child's dental care. Our clinical and administrative staff work closely together to provide a positive environment for visits to our office and assistance with financial requirements. A clear understanding between all of us will help insure that our main concern is with you/your child's dental care.

- All services are payable in full at the time they are provided
- We accept cash, personal check, and certain credit cards ($35 charge on all returned checks)
- We will accept insurance assignment as partial payment on the account. Your deductible and the percentage not covered by your insurance are due at the time services are provided. Dr. John Roberts is not a preferred provider and does not have a contract with any insurance company (we are considered out of network). Dr. Raenie Roberts is in network with Delta Dental.

It is our policy to provide the best dentistry for your family. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. The type of treatment your child needs and will receive from us is based upon our professional judgment and not whether it is covered by a dental insurance plan. Dental benefits are not intended to pay everything, but to assist with cost of dental treatment.

As a courtesy to you, we will submit claims to your dental plan carrier. **However, we do not guarantee any estimate, and should your dental plan pay less than expected, you are fully responsible for the balance. We take no responsibility for any denials by dental plans.**

Consent for Dental Treatment

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Roberts and staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I give Dr. Roberts and staff permission to send records or x-rays to another facility/doctor if requested. The signature of a parent or guardian affixed below authorizes the completing of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefit be denied. I have read the above conditions of treatment and agree to their content.

_____ _____ _____

Signature Relationship to patient Date