New Patient Application for _____ Date _____

Preferred Name_____ DOB_____ Age_____ Gender: Male / Female

Address_____ City_____ Zip Code_____

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? _____

Guardian Information

Name_____ Relation to patient _____DOB_____

Social Security _____ Cell Phone_____ □ Single □Married □Divorced □Widowed

Address_____ City_____ Zip Code_____

Email _____

Name_____ Relation to patient _____DOB_____

Social Security _____ Cell Phone_____ □ Single □Married □Divorced □Widowed

Address_____ City_____ Zip Code_____

Email _____

Insurance Information

Name of Insured_____ Group #_____ Subscriber ID #_____

Insurance Company Name_____ Insurance Phone _____

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 _____

CONTINUED ON BACK SIDE

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 for which the patient has been diagnosed/treated/observed:

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

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 arrangements. A clear understanding between all of us will help ensure that our main concern is with you/your child's dental care. It is our policy to provide the best dentistry for your family. To do this, it is important that we do not allow insurance 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.

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.**

- All services are payable in full at the time they are provided.
- We accept cash, Visa, MasterCard, and CareCredit.
- Your deductible and any percentage not covered by your insurance are due at the time services are provided.
- Dr. Raenie Roberts is in-network with Delta Dental. Dr John Roberts does not have a contract with any insurance companies (we are considered out-of-network).

Consent for Dental Treatment

The information I have given is correct to the best of my knowledge. I understand 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 below authorizes the completing of all agreed upon dental treatment and the use of methods appropriate thereto. This consent remains 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 insurance benefit be denied. I have read the above conditions of treatment and agree to their content.

_____ _____ _____
Signature Relationship to patient Date