



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

Guardian's Name _____ DOB _____ Social Security _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Employer Name and Address _____ Work Phone _____

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Address _____ Home Phone _____

Email _____ Cell Phone _____

Employer Name and Address _____ Work Phone _____

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 _____

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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 and Dr. John Roberts are in-network with Delta Dental. We do not have a contract with any other 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