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PATIENT REGISTRATION

CHILD'S NAME _____ AGE _____ SEX _____

NICKNAME _____ BEST PHONE # TO CONFIRM APPT. _____

ADDRESS _____ CITY _____ ZIP _____

DATE OF BIRTH _____ SCHOOL _____ GRADE _____

REFERRED BY _____ E-MAIL ADDRESS: _____

BROTHERS/SISTERS (NAMES) _____ HAVE WE SEEN THEM IN OUR OFFICE? (CIRCLE NAME)

FATHER'S NAME _____ DATE OF BIRTH _____

HOME PHONE # _____ CELL PHONE # _____

ADDRESS _____ ZIP _____

(If different from child's)

EMPLOYER _____ PHONE _____

MOTHER'S NAME _____ DATE OF BIRTH _____

HOME PHONE # _____ CELL PHONE # _____

ADDRESS _____ ZIP _____

(If different from child's)

EMPLOYER _____ PHONE _____

EMERGENCY CONTACT OTHER THAN PARENT

NAME _____ PHONE _____

I have been offered a copy of the "Notice of Privacy Practices." _____

SIGNATURE

Welcome to Fun!

MEDICAL INFORMATION

Has your child had a history of: *(check those that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Allergies ___ Food ___ Latex ___ Seasonal | <input type="checkbox"/> Heart Murmur ___ Antibiotic |
| <input type="checkbox"/> Asthma or ___ Reactive Airway Disease | <input type="checkbox"/> Prophylaxis Need? |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hepatitis (Type _____) |
| <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> High Fevers |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Hospitalization _____ |
| <input type="checkbox"/> Birth Defects | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Immunodeficiency |
| <input type="checkbox"/> Chronic Respiratory Problems | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cleft Lip or Palate | <input type="checkbox"/> Learning Disabled |
| <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Physically Challenged |
| <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Sensory Integration Disorder |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Speech Disorder |
| <input type="checkbox"/> GERD/Acid Reflux | <input type="checkbox"/> Surgery _____ |
| <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other _____ |

Does your child take any medications? _____

Medication taken at the present time: _____

_____ Dosage _____

Allergy to medications? _____

DENTAL INFORMATION

- | | |
|---|---|
| <input type="checkbox"/> Dental Pain | <input type="checkbox"/> Thumb/Pacifier Habit |
| <input type="checkbox"/> Sores in Mouth | <input type="checkbox"/> Sealants |
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Extracted Teeth |
| <input type="checkbox"/> Injured Teeth | <input type="checkbox"/> "Crooked" Teeth |
| <input type="checkbox"/> Unfavorable Dental; Medical Experience <i>(please explain)</i> | |

Do you have a specific concern about your child's teeth? _____

When are your child's teeth cleaned at home? _____

What does your child snack on between meals? _____

FINANCIAL POLICY FOR DENTAL CARE

Our practice is committed to providing the best service and treatment to our patients. The fees reflect our commitment to quality restorative dentistry using the latest technology. This commitment extends to all areas of the office including less frequently seen areas such as continuing staff education and precise sterilization techniques.

Insurance:

Professional fees are the parents (or guardians) responsibility whether your insurance company pays or not. Our office policy is to collect 50% of restorative charges on the date service is rendered.

Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. Please be aware that some, and perhaps all, of the services can be defined by your insurance company as "not necessary" or "not covered." Our experience over the years has shown that most dental insurance companies only pay about 50% of our restorative fees even though they may advertise payment at an 80% level. You are still responsible for payment of all treatment balances regardless of an insurance company's arbitrary determination of "usual and customary" fees (UCR). If your insurance company has not paid your account in full within 45 days, the balance will automatically become your responsibility.

Out of concern for the health of our staff and patients, we do not use silver (mercury) fillings in our office. Some insurance plans do not cover white (composite) fillings. They will pay for silver (mercury) fillings, which can be applied towards the fee for white fillings. However, you will be responsible for the differences between the charges.

Late Charges:

If payment on an account becomes delinquent, late charges will be added, as well as any collection costs incurred.

Parent or Guardian:

It is the policy of this office that the party present at the time of treatment is responsible for payment at the time of treatment. Any legal agreements between parents, guardians, etc, regarding payment should be resolved prior to the scheduled date of treatment. Failure by one or both parties to remit payment prior to treatment will result in the rescheduling of that treatment.

Our goal is to serve you to the best of our ability. Please let us know if you have questions or concerns at any time.

FULL PAYMENT IS DUE AT TIME OF SERVICE

- WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AMERICAN EXPRESS OR DISCOVER CARD
- WE OFFER AN EXTENDED PAYMENT PLAN THROUGH "CARE CREDIT" (w.a.c.)

I have read, understand, and agree to this Financial Policy.

X _____

Date: _____

Signature of Parent or Responsible Party

CONSENT FOR TREATMENT

State law requires us to obtain your consent for contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.

1. I hereby authorize and direct Dr. James and/or Dr. Elkins, assisted by other dentists and/or dental auxiliaries of his/her choice, to perform upon my child or legal ward, dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

2. In general terms the dental procedure(s) may include:
 - A. Cleaning of the teeth and the application of topical fluoride.
 - B. Application of plastic "sealants" to the grooves of teeth.
 - C. Treatment of diseased or injured teeth with dental restoration (filling or crowns).
 - D. Removal (extraction) of one or more teeth.
 - F. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
 - G. Use of sedative nitrous oxide/oxygen if needed to assist in a more pleasant dental treatment.
 - H. Other: _____

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I further authorize the doctor to perform other dental service(s) that in his/her judgment are advisable for my child or legal ward, with the exception of (if none so state): _____

3. Although their occurrence is extremely rare, some risks have been reported to be associated with dental or oral surgery procedures. State Law requires us to mention the possible risk of numbness, infection, swelling, bleeding, discoloration, aspiration of foreign objects, vomiting, nausea, and allergic reactions. I further understand and accept that complications may require hospitalization and may even result in death. I hereby state that I have read and understand this consent, and that all questions have been answered in a satisfactory manner, and I understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

X _____
Signature of Parent or Guardian

Date: _____

X _____
Signature of Signature of Dentist or Staff

Date: _____

PRIMARY DENTAL INSURANCE

Insurance Company Name: _____ Phone Number: _____

Insurance Company Address: _____

Group #: _____ Member ID#: _____

Insured's Name as appears on card: _____

DOB: _____ SSN: _____

Relation: _____ Insured's Employer: _____

SECONDARY DENTAL INSURANCE

Insurance Company Name: _____ Phone Number: _____

Insurance Company Address: _____

Group #: _____ Member ID#: _____

Insured's Name as appears on card: _____

DOB: _____ SSN: _____

Relation: _____ Insured's Employer: _____

Signature: _____ Date: _____