



**Patient Registration Form**

**Patient Information**

**Please fill out completely**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Sex: Male \_\_\_ Female \_\_\_

\_\_\_\_\_

**Parent/ Guardian information**

Parents Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home#: \_\_\_\_\_

Cell#: \_\_\_\_\_

E- Mail Address: \_\_\_\_\_

SSN#: \_\_\_\_\_

Driver License#: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_

\_\_\_\_\_

Spouses Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Drivers License#: \_\_\_\_\_

SSN#: \_\_\_\_\_

Employer: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Address: \_\_\_\_\_

\_\_\_\_\_

**Referred By**

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Emergency Contact**

Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

**Please give 24 hrs advance notice if unable to keep an appointment.**

**Appointments not cancelled within 24 hrs or missed appointments are billed at the rate of \$50.00**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Financial Policy**

It is our financial policy to collect fees at the time service was provided. For your convenience, we accept cash, check, MasterCard, Visa, American Express, and Discover. If you wish to pay out your balance with monthly payments, we are pleased to offer you three, six, or twelve months interest free through a program called Care Credit. You may request an application at the window, and it is free to apply. If you do not qualify for this program, please be prepared to pay your account in full at the time of checkout. Any unpaid balance is subject to actions by a professional collection agency up to and including legal actions by the State District Attorney's Office.

**Dental Insurance Holders**

As a courtesy to our patients, we will be happy to file claims with your insurance provided that you supply us with accurate and up to date information. Your dental insurance is a contract between the insurance company and you the policy holder; **WE ARE NOT A PART OF THAT AGREEMENT.** Please be aware that state law requires us to collect any deductible, co-pay, or benefits for any reason, **YOU** remain financially responsible for the balance on your account. This is due immediately, and it will be expected that you make arrangements to clear your account accordingly.

Our fees are usually covered up to the maximum paid by your insurance. Some insurers pay claims as a percentage (i.e. 50%, 80%, etc.) of what they regard as the "Usual and Customary" charge for their plans. Our fees are considered appropriate for pediatric dentistry in this area.

**If you have any questions please feel free to contact any member of my staff prior to the start of your child's treatment.**

**Authorization to Treat:**

I authorize Donna J. Barefield, DDS, MSD and/ or her associates to treat the aforementioned patient using restorative and/ or surgery techniques that are reasonable and necessary as the doctor deems advisable, including the use of nitrous oxide (laughing gas). I understand that the treatment plan presented, along with the fee outlined, could change depending upon the time elapsed since the examination and the extent of decay.

Signed \_\_\_\_\_

Date \_\_\_\_\_

**Assignment of benefits:**

In consideration of services rendered I hereby transfer and assign to Donna J. Barefield, DDS, MSD and her associates all right title and interest in any payment due me for services provided in the policy and polices of insurance held by me. I further agree and authorize Donna J. Barefield, DDS, MSD to release information requested by the insurance company or its representatives.

Signed \_\_\_\_\_

Date \_\_\_\_\_

**Release:**

I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read the Financial Policy above and completed the patient registration form. This information is true and correct to the best of my knowledge. I am responsible for notifying you of any changes.

Signed \_\_\_\_\_

Date \_\_\_\_\_

## PATIENT ACQUAINTANCE RECORD

**Please note: This form must be completed by the child's parent/legal guardian.**

Child's name: \_\_\_\_\_ Sex:  M  F Age: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_  
Physician's name: \_\_\_\_\_  
Physician's phone number: \_\_\_\_\_ and FAX number: \_\_\_\_\_

**In order for us to provide dental care for your child in a safe and appropriate manner we will need to have a thorough understanding of your child's physical and emotional history and conditions. Please mark the items listed below that your child has had in the past or currently has. Please do not omit any facts. Thank you.**

- |  |   |
|--|---|
| <input type="checkbox"/> Birth defects or Syndromes    | <input type="checkbox"/> Allergy to rubber or latex                                 |
| <input type="checkbox"/> Large tonsils                 | <input type="checkbox"/> ADD or ADHD  |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Kidney disease   |
| <input type="checkbox"/> Cystic Fibrosis               | <input type="checkbox"/> Autism   |
| <input type="checkbox"/> Breathing problems            | <input type="checkbox"/> Shunt placement  |
| <input type="checkbox"/> Sleep Apnea                   | <input type="checkbox"/> Tuberculosis   |
| <input type="checkbox"/> Diabetes                      | <input type="checkbox"/> Emotional/Mental/Developmental condition                   |
| <input type="checkbox"/> Heart Disease/Condition       | <input type="checkbox"/> Hepatitis/Jaundice/Liver disease                           |
| <input type="checkbox"/> Heart Murmur                  | <input type="checkbox"/> Artificial joints, valves, plates, or devices              |
| <input type="checkbox"/> Abnormal blood pressure       | <input type="checkbox"/> Adverse reaction to local anesthetic ('caine' anesthetics) |
| <input type="checkbox"/> Rheumatic Fever               | <input type="checkbox"/> Anemia   |
| <input type="checkbox"/> Epilepsy                      | <input type="checkbox"/> Cerebral Palsy/Neurologic disorder                         |
| <input type="checkbox"/> Seizures                      | <input type="checkbox"/> Thyroid or Endocrine disease                               |
| <input type="checkbox"/> Prolonged bleeding/hemophilia | <input type="checkbox"/> Food/Dye/Environmental allergy                             |
| <input type="checkbox"/> Sickle Cell Disease or Trait  | <input type="checkbox"/> Speech difficulty  |
| <input type="checkbox"/> Cancer/Tumors/Malignancies    | <input type="checkbox"/> Eye or sight disorder                                      |
| <input type="checkbox"/> HIV positive                  | <input type="checkbox"/> Hearing loss or ear problems                               |
| <input type="checkbox"/> Cleft Lip or Palate           | <input type="checkbox"/> Mouth injuries   |
| <input type="checkbox"/> Eczema/Psoriasis              | <input type="checkbox"/> Skin infections/Ringworm                                   |

**Please list any medicines your child is currently taking:**

**Please list any medicines that have caused an allergic reaction for your child:**

**Please list any surgeries or hospitalizations your child has undergone:**

**Please list any adverse reactions your child has experienced with sedatives:**

**Please list any unfavorable experiences your child has had due to a medical or dental procedure:**

\_\_\_\_\_  
Name of person completing this form (Please **PRINT**)

\_\_\_\_\_  
Relation to patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Signature of dentist reviewing history

**CONSENT FOR ABSENT PARENT**

Patients Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

In the event that I cannot be present in the office for my child's dental care, I hereby give the following named relatives permission to bring my child to dental appointments and to make any and all treatment decisions for my child. I attest that the named individuals are 21+ years of age.

1) \_\_\_\_\_ (relationship to patient)

2) \_\_\_\_\_ (relationship to patient)

3) \_\_\_\_\_ (relationship to patient)

I understand treatment of the primary or permanent teeth rendered for my child during my absence can include, but is not limited to examination, x-rays, dental cleaning, fluoride treatment, white plastic fillings, metal crowns, white plastic crowns, nerve treatments/ pulp therapy, extractions, sealants, space maintainers, treatment for dental/ medical emergencies. I further acknowledge and understand that my child will be treated using nitrous oxide/ oxygen analgesia (laughing gas), and may require local anesthesia injection for numbing.

I attest that I am the parent/ legal guardian of the child named at the top of this form, and I give consent for the above named individuals to make any and all treatment decisions for my child in my absence.

\_\_\_\_\_

Printed Name of Parent/Legal Guardian

\_\_\_\_\_

Relationship to patient

\_\_\_\_\_

Signature of Parent /Legal Guardian

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Date

**Consent for Use of Disclosure of Health Information  
& Acknowledgement of Receipt of Notice of Privacy Practices**

**Section A: Patient Giving Consent**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

**Section B: To The Patient- Please Read The Following Statements Carefully.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at anytime by contacting: Irene Lopez, 400 E. US Highway 67, Duncanville, TX 75137, (214)-339-5150

**Right to Revoke:** You will have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

**SIGNATURE: \*\*You may refuse to sign this. You are entitled to a copy of this after you sign it\*\***

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to you to use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. I have reviewed a copy of this office's Notice of Privacy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_