EASTSHORE PEDIATRIC DENTAL GROUP
TERI L. KIM, DDS THEA S. DOSANJH, DDS

Patient Registration Form

Child's name_____ Nickname: _____ Sex: (M) (F)

Date of birth: _____ Age: _____ Purpose of Visit: _____

Does your child have any special needs or fears _____

School: _____ Grade: _____ Hobbies/interests: _____

Adopted? (Y) (N) Names and ages of other siblings: _____

How did you hear about our practice? _____

General Information

Parent 1 name: _____DOB _____ Relationship to child_____

Parent 2 name: _____DOB _____ Relationship to child_____

Who does the patient live with? (Mother/ Father/ Both Parents/ Other) _____

Home Address_____City_____Zip Code_____

Home Phone_____ Email address;_____

How would you like us to contact you? Home Work Cell Email

Parent 1 Employer_____ Mobile phone: _____Work Phone: _____

Parent 2 Employer_____ Mobile phone: _____Work Phone: _____

Who is the person financially responsible for your child's dental care? _____

Dental Benefit Plan Information

Do you have dental insurance? (Y) (N)

Primary dental plan name: _____Name of insured:_____

Address of insurance company: _____

ID number: _____ Group/Policy number: _____

Secondary dental plan name: _____Name of insured:_____

Address of insurance company: _____

ID number: _____ Group/Policy number: _____

Medical Plan Information

Plan name: _____Name of Insured_____

Address of insurance company_____

ID number: _____Policy number_____

Consent for Dental Treatment

I request and authorize this dental team to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Dosanjh or Dr. Kim to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I authorize this dental team to perform any necessary dental services that my child may need and have consented to during diagnosis and treatment. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Dosanjh and Dr. Kim will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments.

_____ _____ _____

Signature Relationship to patient Date

Financial Agreement

It is our primary goal and responsibility to help our patients obtain good dental health. So that we may help our patients maximize their dental benefits, we have chosen to be a participating provider with many dental PPO plans. Dental benefit plans are a contract between you or your employer and the plan, and plan benefits are based on the terms of this contract. If you have dental insurance, we will be happy to assist you in estimating your portion of the cost of treatment, but we would strongly recommend you become familiar with your insurance benefits ahead of time. For patients without insurance, payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance.

If Eastshore Pediatric Dental Group is a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. Your portion may include deductibles, co-payments or certain procedures not covered by your insurance policy. Eastshore Pediatric Dental Group is required to collect the patient's portion in full at time of service.

If Eastshore Pediatric Dental Group is not a contracted provider with your plan, it is your responsibility to contact your plan to determine whether they allow patients to receive reimbursement for services from out of network providers. If so, you may "assign benefits" to us, and we will file for your insurance benefits as a courtesy to you. We do our best to provide you with an accurate estimate for services. However, you are responsible for any unpaid balance after the receipt of payment from the plan to our practice, even if that amount is different than the estimated amount we gave you. Although rare, some insurance carriers will not reimburse our office directly. In such instances, you will be responsible for the full cost of each visit at the time services are provided, and your insurance company will send you the reimbursement check, filled out in your name, directly.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept cash, personal check, debit cards, Visa, and MasterCard. We also accept third party financing through CareCredit. **There will be a $50.00 charge for returned checks.**

Authorization

I understand the information I have given today is correct to the best of my knowledge. I have read the above and agree to the financial terms. I authorize the release of any information including diagnosis and records necessary to process my dental benefit claims. I understand that failure to keep my account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I hereby authorize payment directly to Eastshore Pediatric Dental Group otherwise payable to me.

_____ _____ _____

Signature Relationship to patient Date