



**Lake Orion**  
**FAMILY DENTISTRY**  
*Care that's close to home,  
but far from ordinary*

1375 South Lapeer Road, Suite 200  
Lake Orion, Michigan 48360  
(248) 693-6213

### Child Registration Form

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

Male  Female Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
(Cell) \_\_\_\_\_ E-Mail: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Health Information

Previous Dentist: \_\_\_\_\_ Date of Last Dental Visit: \_\_\_\_\_

Reason for this visit: \_\_\_\_\_

**Has your child ever had any of the following? Please check those that apply:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> AIDS                      | <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Kidney Disease                 | <input type="checkbox"/> Thyroid Problems  |
| <input type="checkbox"/> Allergies _____           | <input type="checkbox"/> Emphysema                        | <input type="checkbox"/> Latex Sensitivity              | <input type="checkbox"/> Tuberculosis  |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Epilepsy                         | <input type="checkbox"/> Liver Disease                  | <input type="checkbox"/> Tumors  |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Excessive Bleeding               | <input type="checkbox"/> Mental Disorders               | <input type="checkbox"/> Ulcers  |
| <input type="checkbox"/> Artificial Joints         | <input type="checkbox"/> Fainting                         | <input type="checkbox"/> Mitral Valve Prolapse          | <input type="checkbox"/> Venereal Disease  |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Glaucoma                         | <input type="checkbox"/> Nervous Disorders              | <input type="checkbox"/> Codeine Allergy   |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Growths                          | <input type="checkbox"/> Pacemaker                      | <input type="checkbox"/> Penicillin Allergy  |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Hay Fever                        | <input type="checkbox"/> Psychiatric/Psychological Care | <input type="checkbox"/> Allergic/Adverse Reaction To<br>Medication or Any Substance,<br>Please specify:<br>_____<br>_____ |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> H. I. V. Positive                | <input type="checkbox"/> Radiation Treatment            | <input type="checkbox"/> Other: _____  |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Head Injuries                    | <input type="checkbox"/> Respiratory Problems           |  |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart (Attack, Disease, Surgery) | <input type="checkbox"/> Rheumatic Fever                |  |
| <input type="checkbox"/> Contact Lenses            | <input type="checkbox"/> Heart Murmur                     | <input type="checkbox"/> Rheumatism                     |  |
| <input type="checkbox"/> Cortisone Medication      | <input type="checkbox"/> Hemophilia                       | <input type="checkbox"/> Sinus Problems                 |  |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hepatitis                        | <input type="checkbox"/> Smoke/Chew Tobacco             |  |
| <input type="checkbox"/> Diet (Special/Restricted) | <input type="checkbox"/> High Blood Pressure              | <input type="checkbox"/> Stomach Problems               |  |
|  | <input type="checkbox"/> Jaundice                         | <input type="checkbox"/> Stroke                         |  |

• Has your child ever had complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Has your child been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Is your child currently under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_  
Phone: \_\_\_\_\_

• Any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

• Is your child taking any medications? Please list \_\_\_\_\_

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child has any change health, I will inform the doctor at the next appointment without fail.**

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Doctor \_\_\_\_\_ Date: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another Doctor  Dental Office  
 School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Responsible Party Information

The following is for:  the patient's parent  the person responsible for payment

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

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apartment #

City State Zip Code

Please list people to whom we are authorized to divulge your private medical information \_\_\_\_\_  
\_\_\_\_\_

### Employment Information

The following is for:  the patient's parent  the person responsible for payment

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

### Primary Insurance Information

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group # \_\_\_\_\_ SS# \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Plan Name and Telephone: \_\_\_\_\_

### Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group # \_\_\_\_\_ SS# \_\_\_\_\_

Insured's Address: \_\_\_\_\_  
Street City State Zip Code

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Insurance Plan Name and Telephone: \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from the patients for the costs incurred in their care, and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Our office will prepare and submit dental insurance forms on behalf of the patient. The patient will be responsible for all estimated copays and deductibles on the date of service. After payment from the insurance company we will bill the patient for any unpaid balances.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding sixty (60) days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate provided by this office for my child's dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services rendered to my child, by the Doctor, I agree to pay the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Further, I understand and acknowledge that photographs and images of my child may be shown to other patients and doctors for treatment and educational purposes and I agree to the same.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

**I have read the above conditions of treatment and payment and agree to their content.**

\_\_\_\_\_  
Signature of patient, parent or guardian      Date: \_\_\_\_\_      Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party      Date: \_\_\_\_\_      Relationship to Patient: \_\_\_\_\_