PEDIATRIC PATIENT REGISTRATION

DATE _____

PATIENT'S NAME _____ MALE ___ FEMALE ___
BIRTH DATE _____ NAME YOUR CHILD GOES BY _____
ADDRESS _____
CITY STATE ZIP
PATIENT LIVES WITH: ___ MOTHER ___ FATHER ___ BOTH ___ OTHER
FATHER'S NAME _____ SSN _____
BIRTH DATE _____ PHONE # _____ CELL # _____
ADDRESS _____
CITY STATE ZIP
EMPLOYER _____ OCCUPATION _____
BUSINESS ADDRESS _____
CITY STATE ZIP
BUSINESS PHONE # _____
MOTHER'S NAME _____ SSN _____
BIRTH DATE _____ PHONE # _____ CELL # _____
ADDRESS _____
CITY STATE ZIP
EMPLOYER _____ OCCUPATION _____
BUSINESS ADDRESS _____
CITY STATE ZIP
BUSINESS PHONE # _____

INSURANCE: Please complete the following information regarding dental insurance:

Primary Carrier Insurance Company _____
Mailing Address _____
Employee _____ Insured ID # _____ Group # _____
Date of Birth of Employee _____
Secondary Insurance Company _____
Mailing Address _____
Employee _____ Insured ID # _____ Group # _____
Date of Birth of Employee _____

PREFERRED METHOD OF PAYMENT _____CASH _____CHECK _____CREDIT CARD

FINANCIAL AGREEMENT AND CONSENT

The undersigned agrees to pay in full those amounts charged by Dr. Vasudha Basava, DDS, LLC, herein after referred to as the "Doctors" for services rendered from time to time, to the undersigned, the patient whose name appears above, or any member of my immediate family which include my spouse, children, step-children and any other dependent/s living in my household. I understand and agree that what my insurance company does not pay, is my responsibility, I also understand and agree that I will be responsible for check fees for returned checks (whether or not written or tendered by me). I further agree that if scheduled appointments are broken, unless this office is notified at least 24 hours in advance, I will be responsible for a fee of $70.00 for each broken appointment. I further understand and agree that any amounts owed are due within 30 days of service. I further agree to pay interest on my account at the rate of 1½ % per month on amounts owed after 30-day period stated, herein, unless financial arrangements in writing have been made in advance. If the Doctors view my account delinquent and they deem it appropriate to refer this matter for collection, I consent and authorize them releasing to a third party or agent, all information, medical or otherwise, in my file necessary for pursuing collection against me or any responsible party. I am aware that I can revoke this authorization at any time except to the extent that action has been taken in reliance thereon.

SIGNATURE: _____
DATE

UPON SIGNATURE OF THE ABOVE SIGNED TRENTON FAMILY DENTAL CARE. AGREE TO RENDER SERVICES TO THE ABOVE SIGNED AND FAMILY AS INDICATED ABOVE.

PLEASE TURN OVER →

MEDICAL HEALTH

PHYSICIAN'S NAME _____

ADDRESS _____

DATE OF LAST MEDICAL EXAM _____

Are you allergic to: _____ Penicillin _____ Codeine _____ Local Anesthetics _____ Other Meds-Please list

_____

_____

PLEASE CHECK YES OR NO TO THE FOLLOWING:

	YES	NO		YES	NO
Hemophilia	○	○	Autism/Autistic Tendency	○	○
Asthma	○	○	Venereal Disease	○	○
Allergies	○	○	Scarlet Fever	○	○
Bronchitis	○	○	Diabetes	○	○
Convulsions	○	○	Tuberculosis	○	○
HIV/Virus AIDS	○	○	Hepatitis	○	○
Anemia	○	○	Faints Easily	○	○
Heart Trouble	○	○	High Blood Pressure	○	○
Mitral Valve Prolapse	○	○	Kidney Trouble	○	○
Stomach Problems	○	○	Excessive Bleeding	○	○
Rheumatic Fever	○	○	Pyorrhea/Bleeding Gums	○	○
ADD/ADH	○	○	Developmental Delay/Disability	○	○

Please discuss any current medical treatment, impending operations or any other information that may possibly affect your dental treatment. _____

_____

_____

_____

Please check YES or NO for consent to the following for the purpose of dental treatment.

	YES	NO
Fluoride treatment	○	○
Radiographic examination (X-rays) for dental treatment	○	○
Local anesthesia (injections) "Numbing medication"	○	○
Nitrous oxide analgesia "Assists patient in relaxing"	○	○

I have completed and reviewed the above questionnaire. All statements are true to the best of my knowledge. I consent to all necessary dental treatment of my child.

Parent's Signature _____