Southgate Dental Care
Comfortable, Personalized Care

MINOR / CHILD REGISTRATION

NAME: _____DOB: _____ AGE: _____

ADDRESS: _____CITY: _____STATE: _____

ZIP :_____ HOW LONG: _____HOME PHONE: _____

MOTHER'S NAME:_____DOB:_____SS#_____

OCCUPATION:_____EMPLOYED BY:_____

WORK ADDRESS:_____WORK PHONE:_____

FATHER'S NAME:_____DOB:_____SS#_____

OCCUPATION:_____EMPLOYED BY:_____

WORK ADDRESS:_____WORK PHONE:_____

PARENT'S MARITAL STATUS: MARRIED _____SINGLE _____SEPARATED/DIVORCED_____

PERSON RESPONSIBLE FOR ACCOUNT:_____

CELL PHONE:_____E-MAIL:_____

WHO OTHER THAN PARENTS CAN WE NOTIFY IN CASE OF EMERGENCY?_____

IS CHILD COVERED BY A DENTAL INSURANCE PLAN?

YES_____ NO_____ IF YES, ANSWER THE FOLLOWING:

EMPLOYEE COVERED: _____SS#/ID#_____

DENTAL INS.PLAN:_____GROUP #_____PHONE#_____

How did you hear about us? (Circle) Web Site, Insurance Plan, Family/Friend_____ Other_____

RELEASE OF INFORMATION

PATIENT(S) NAME:_____

I authorize release of any information relative to dental treatment received in the office of Mark F. Eisenberg, D.D.S. & Associates P.A.
SIGNED: (Parent/Patient): _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of group benefits, otherwise payable, to me, to the named provided for professional services rendered.
I understand that I am responsible for all costs of dental treatment.
SIGNED: (Parent/Patient):_____

STATEMENT OF RESPONSIBILITY

In consideration of the services rendered by the offices of Mark F. Eisenberg, D.D.S.,& Associates, P.A., the undersigned agrees to pay all bills rendered by that office and to be primarily responsible for same.
Delinquent accounts are subject to one and one-half percent (1.5%) per month late charges or $8.00 billing charge on the unpaid balance, plus all reasonable collection charges which shall include but not limited to, all reasonable Attorney's fees, suit fees, agency fees, court costs and Private Process Service expense incurred as a result of the failure to pay the aforementioned bills rendered. The undersigned further hereby waives any claims under the Statute of Limitations and acknowledges receipt of a copy of the statement of responsibility.

_____ _____

WITNESS **SIGNATURE**

DATE:_____

Southgate Dental Care

MINOR/CHILD MEDICAL HISTORY

Name: _____Age:_____Date:_____
Minor/Child Physician:_____
Address: _____ Phone:_____
Date of last physical exam: _____ Results: _____
Is minor/child under care of physician now?_____ For what?_____
Receiving any medications or drugs? _____ If yes, please list below:
_____
Ever been hospitalized? _____
Ever had surgery? _____
Is there excessive bleeding when cut? _____
Allergies: _____

Has minor/child had any history of or difficulty with any of the following?
(If yes please check)

❑ HIV Virus or AIDS	❑ Cerebral Palsy	❑ Epilepsy
❑ Anemia	❑ Chicken Pox	❑Fainting
❑ Asthma	❑ Convulsions	❑ Hearing Problems
❑Bladder Problems	❑ Diabetes	❑Heart Problems
❑ Cancer	❑ Drug/Alcohol Abuse	❑ Hepatitis
❑ Kidney Disease	❑ Rheumatic Fever	❑ Liver Disease
❑Sinus Problems	❑ Thyroid Disease	❑Measles
❑ Mononucleosis	❑ Tuberculosis	❑Mumps

Other _____

Has your child had any hearing, sight, speech, coordination or other special problems? _____ If yes, please explain: _____
_____
Has your child experienced any unfavorable or undesirable reaction from any Previous medical or dental care? _____ If yes, please explain: _____
_____
Does your child have any emotional, mental or nervous disorders? _____
If yes, please explain: _____
_____
Child's grade in school? _____
Does your child have any other health problems not mentioned? If so, explain:
_____
_____

Southgate Dental Care

MINOR/CHILD DENTAL HISTORY

Minor/Child's Name: _____Age:_____ Date:_____

Reason for visit: _____

Is child experiencing any dental pain or discomfort now? _____

Is this child's first visit to the dentist? _____

If no, date of last visit: _____ Dentist: _____

Has your child ever had (circle if yes) ***toothache, teeth sensitive to sweets, teeth sensitive to hot or cold , chipped teeth, cavities, crooked teeth or discolored teeth?***

Does your child have a history of (circle if yes) ***thumb sucking, nail biting, tongue thrusting, mouth breathing or using a pacifier?***

Was your child bottle-fed? _____ To what age? _____

Do you have well water? _____

Any lost or missing teeth? _____

Does your child brush teeth daily? _____

Does your child take any fluoride supplements? _____

Do you assist your child in brushing his/her teeth? _____

Is your child worried about the visit with the dentist? _____

Do you desire complete dental care for your child? _____

Do you have any questions or special problems? _____

I have answered the above questions about minor/child's medical and dental history accurately and to the best of my knowledge. This signature of a parent or guardian affixed below authorizes the completion of all agreed upon necessary dental services.

Signature Parent/Legal Guardian: _____

Relationship to child: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____