DINO DENTAL
Breastfeeding.Orthodontics.Pediatrics

PATIENT REGISTRATION FORM

YOUR CHILD'S / CHILDREN'S FULL NAME(S):	Date Of Birth	AGE	GENDER
			M / F
			M / F
			M / F
			M / F

FAMILY INFORMATION

PARENT / LEGAL GUARDIAN	PARENT / LEGAL GUARDIAN
NAME:	NAME:
Address:	Address:
City, State, Zip:	City, State, Zip:
Cell Phone:	Cell Phone:
Home Phone:	Home Phone:
Date of Birth:	Date of Birth:
Email:	Email:

DENTAL INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber Name:	Subscriber Name:
Name of Insurance:	Name of Insurance:
Insurance Phone #:	Insurance Phone #:
Group #: ID #:	Group #: ID #:
Employer:	Employer:

How did you hear about us? (insurance listing / friend / google / etc.)

Dino Dental accepts most dental insurance plans. For your convenience, we send a dental claim to your insurance plan electronically the day your child receives treatment. Your insurance company is obligated to pay the claim within 60 days from the date of submission. At that point, we consider the outstanding charges billable to you, the consumer. You will be sent a statement showing the unpaid claims and/or your financial responsibility after all claims have been processed by your insurance provider. **I understand that I am responsible for any charges that are reasonably denied by my insurance company. By signing below, you consent to your child's treatment and your financial obligation to Dino Dental.**

Parent / Legal Guardian Signature **Date**

Please email form to hello@dinodent.com or fax to (719) 260-1640

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CHILD'S FULL NAME: _____

Date Of Birth: _____ **AGE:** _____ **Gender: M / F**

MEDICAL HISTORY

Who is your child's current pediatrician? Name / Clinic _____

1. Is your child taking any medication (prescription or over the counter), vitamins or supplements? **YES / NO**
   - List name, dose and frequency: _____
2. Is your child under the care of a physician for any medical condition at this time? **YES / NO**
   - If yes, please explain: _____
3. Has your child ever been hospitalized, had surgery or been treated in an emergency room? **YES / NO**
   - If yes, date and please explain: _____

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS?

Anemia / Blood Disorder	Y	N	Bladder / Kidney Problems	Y	N
Asthma / Difficulty Breathing	Y	N	Liver Disorder	Y	N
Allergies to food / Latex / Seasonal / Other	Y	N	Allergic Reaction to Anesthetic / Antibiotics / Other	Y	N
Cancer / Tumors / Chemo or Radiation Therapy	Y	N	Thyroid Disorder	Y	N
Diabetes / Hyperglycemia / Hypoglycemia	Y	N	Birth Defects / Syndromes	Y	N
Cerebral Palsy / Epilepsy / Seizures	Y	N	Vision / Hearing / Speech Problems	Y	N
Heart Defects / Heart Disease / Murmur	Y	N	Behavioral / Emotional Issues / ADD / ADHD	Y	N
HIV / AIDS	Y	N	Developmental Disorders/Learning Problems/Delays	Y	N
Hepatitis	Y	N	Autism / Autism Spectrum Disorder	Y	N

For each **YES** provide details here:

_____

_____

_____

DENTAL HISTORY

Has your child ever been treated by a general or pediatric dentist? **YES / NO**

- If so, who? _____ Date of last visit: _____

1. How do you expect your child to respond to dental treatment? **WELL FAIR POOR**
2. Is there a family history of cavities? **YES NO** If yes, who? **FATHER MOTHER SIBLING(S)**

DO ANY OF THESE **CURRENTLY** APPLY TO YOUR CHILD?

Cavities / Pain from Teeth	Y	N	Suching Habits (finger, thumb, pacifier, other)	Y	N
Injury to Teeth / Mouth / Head / Lips	Y	N	Non-Spill Training Cup (sippy cup)	Y	N
Breast or Bottle Feeding	Y	N	Stained or Discolored Teeth	Y	N

I am the parent or legal guardian for the above referenced child and am authorized to consent to dental treatment for such child. I have complete knowledge of this child's medical/dental history to accurately and fully complete this form for the child.

_____

Parent / Legal Guardian Signature **Date**

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AUTHORIZATION STATEMENT

_____ (initial) I do hereby authorize Dr. James Busch, Dr. Lauren Busch and their staff of Dino Dental to provide my child with diagnostic and therapeutic procedures, including dental x-rays and photographs, as may be necessary for proper dental care.

_____ (initial) I do hereby understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment by using praise, explanation, and demonstration of procedures and instruments using variable voice tones. I authorize this Dental Office to administer such medication, including the use of nitrous oxide ("laughing gas"), which is a mild sedative that is inhaled to reduce anxiety and/or the use of a mouth prop.

_____ (initial) I do hereby authorize payment directly to this Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and that any estimate given to me is not guaranteed. I authorize the release of any information relative to all claims. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Colorado or any other state.

_____ (initial) I acknowledge that I have read your Notice of Privacy Practices in accordance with The Health Insurance Portability & Accountability act of 1996 (HIPAA), and have been offered a copy of it.

☐ I Agree or and grant full permission for Dino Dental to use either myself or my child's name & photograph in any publication or advertising materials (printed or electronic). This consent always waives the rights of privacy or compensation for the use of photo or name.

☐ I Agree or grant full permission for Dino Dental to use either myself or my child's photograph only, in any publication or advertising materials (printed or electronic). This consent always waives the rights of privacy or compensation for the use of photo.

☐ I Do Not Agree to have mine and my child's information or photographed used.

Whom may we release information to? _____

The information on this page, including the medical history, is correct to the best of my knowledge. I understand that if any of the above information changes, including medical history, that it is my responsibility to inform this Dental Office.

_____ _____

Signature of (circle one): Mother Father Grandparent Guardian Self Date

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Financial Policy Agreement

We are committed to providing you with the highest quality of care. Our fees reflect the quality of care we provide. We continue our commitment by offering a variety of financial options to enable you to receive the dental care you need. We accept cash, check, credit cards, care credit and a 3 month payment schedule. (In 2019 we will offer an in-house membership plan). We will communicate all recommended treatment options and associated fees prior to the start of treatment. Payment for non-insured clients and non-covered services are expected at the time of service.

The parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered unless prior written financial arrangements have been made.

Patients with insurance: As a courtesy, we will file your insurance. Insurance coverage is verified when you first visit our office. However, accurate insurance information with member ID's must be made available in order for us to submit your dental claims. Insurance benefit coverage often changes during open enrollment each year. If the insured changes employers, insurance companies, or insurance benefits, it is the insured's responsibility to notify Dino Dental of these updates. All balances, co-payments, deductibles, and payment for non-covered services are due at the time of service. If you or your insurance carrier makes payment exceeding your balance, you will be refunded or a credit will be applied to your account. We will do everything in our power to see that you receive the benefits you are entitled through your policy, however, after 30 days the balance on the account is your responsibility regardless of insurance.

Remember: Dental insurance is a contract between you, your employer and the insurance company. It is a benefit to ASSIST you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment. It is your responsibility to see that we have the current and accurate information on file for your insurance. You, (not the insurance company) are responsible for the fees of service rendered.

Patients without Insurance: Full payment for your child's care is due in full at the time of service. Payment arrangements need to be made prior to each service. For your convenience, we accept credit cards, cash, and checks. A **10% discount** (*5% discount if paid by credit card*) will be applied for preventative dental services pain in full in cash or check on the date of service. This includes exams, cleanings, and radiographs. A **20% discount** (*15% discount if paid by credit card*) will be applied for any treatment paid in full in cash or check on the date of service. These discounts do not apply with payment plans or payments not paid in full on the date of service.

I have fully read and understand the financial policy listed above, and agree to pay the total balance due on my account for all services rendered by Dino Dental at the time of service. I do hereby agree to pay in full all services not covered by my dental insurance carrier within 15 days of the insurance payment. If I ever default on my account with the office, I will be responsible for legal fees, collection agency fees, interest charges (MPR 1.5%, APR 18%) and any other expenses incurred in collecting my account.

Parent / Legal Guardian Signature Date

8890 North Union Boulevard, Suite 209
Colorado Springs, CO 80920
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Fees

Cancellation and No Show Fees: Dental and orthodontic appointments are reserved for a specific amount of time. Missed appointments and/or rescheduled last minute (less than 24 hours) affects our ability to provide timely attention to all our patients. You will be charged a fee based on our cancellation and no show policy for not showing up or rescheduling within 24 hours for your scheduled appointment. If you are 15 minutes late to your appointment it will be treated as a no show and you will be charged based on our cancellation and no show policy.

Delinquent Accounts: This impedes our ability to provide you with the quality dental care that you deserve. A service charge of 2% per month (24% per annum) on the unpaid balance will be charged on all accounts exceeding 30 day, unless previously written financial arrangements are satisfied.

Check Policy: If your check is returned for any reason, we will charge for the check plus a processing fee of $50.00.

Assignment of Benefits: I assign the benefits from my insurance carries to Dino Dental for dental benefits that my child is entitled to.

Release of Information: I authorize Dino Dental to release any information needed to my insurance carrier(s) to determine benefits or benefits payable for related services rendered.

I have fully read and understand the financial policy listed above, and agree to pay the total balance due on my account for all services rendered by Dino Dental at the time of service. I do hereby agree to pay in full all services not covered by my dental insurance carrier within 15 days of the insurance payment. If I ever default on my account with the office, I will be responsible for legal fees, collection agency fees, collection agency fees, interest charges (MPR 1.5%, APR 18%) and any other expenses incurred in collecting my account.

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Cancellation, No Show and Rescheduling Policy

Dental and orthodontic appointments are reserved for a specific amount of time with the doctors. Missed appointments and/or rescheduling them affect our ability to provide timely attention to patients. If you are unable to make your appointment or need to reschedule, we respectfully ask that you notify our office at least 24 hours prior to your appointment time. This policy does not apply if your child is sick or you have a family emergency. Failure to cancel an appointment that you do not attend or reschedule an appointment without appropriate notice will be considered a missed appointment and or now show and you will be charged accordingly (please note that fees apply to per patient):

Cleaning and/or exam:	$35.00
Treatment with or without nitrous oxide:	$50.00
Treatment with oral sedation:	$75.00
Treatment with general anesthesia:	$300.00

I have read the above and understand the above policy. I will do everything I can to assure appointments have been confirmed and that I arrive on that specified day and time. I also understand that there may be extenuating circumstances that arise in which I have to make a last minute cancellation. Dino Dental understands unexpected situations arise and will try to be accommodating.

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