BOULDER HOLISTIC DENTISTRY

Child's Name ____ Date of birth_____________

School ____ Grade __________________

Parents' name(s) ____

Home Address____ Phone __________________

____ Phone __________________

Whom may we thank for referring you? ____

Child's physician____ Phone __________________

Is the child: in good health? YES NO

under a doctor's care for any problem? YES NO

taking medications now or within the last year? YES NO

If yes, what?

following a particular diet? YES NO

ever had a serious illness or operation YES NO

Please check if the child has ever had:

_____ Allergies _____ Bleeding problems

_____ Asthma _____ Heart murmur

_____ Diabetes _____ Heart problems of any sort

_____ Epilepsy _____ Rheumatic fever or scarlet fever

_____ Adverse reaction to penicillin, novocaine or other drugs

Has the child been to a dentist before? YES NO

Was the experience positive, neutral or negative?

Has the child lived in an area with fluoridated water? YES NO

Or taken fluoride supplements? YES NO

What brand of toothpaste does the child use?

Is there anything else we should know about the child's health and development?

Parent's signature ____ Date _________________

Financial Registration

Patient's Name ________________________________

Payment is due at the time of service:

- ☐ Cash or check at the time of service – receive 5% discount for full payment.
- ☐ Credit card at the time of service – We take Visa, Mastercard, Discvoer and American Express.
- ☐ Other payment arrangements must be made in advance.

How we handle dental insurance: We will be happy to do the paperwork for insurance submission. We prefer that you pay for care at the time of service, and receive reimbursement from your insurance. (They usually pay you faster than us!) If you need to have us bill your insurance first, please provide us with a credit card number to guarantee your copayment.

Please be advised that dental insurance coverage varies widely, and the companies' notions of "usual, customary and reasonable" fees also vary widely. This office cannot be responsible for the level of benefits provided by your company.

Insured person: With dental insurance, this is the employee, or person to whom the policy is issued. (Not the dependent.) *All fields are required:*

Insured Person's Name ______________________________ Emplyer ____________________

Insured Person's Member ID # ________________________ or Soc Sec # __________________

Insurance Company __________________________________ Group # __________________

Address _______________________________________ Phone # _________________

____

Patient's relationship to insured person ________________________

Statement of permission and financial responsibility

By signing below, I give permission to Boulder Holistic Dentistry to perform necessary dental procedures. The nature, purpose and risks of all such procedures will be explained.

By signing below, I acknowledge that I am responsible for all charges arising from services provided. I understand that, unless other arrangements are made, payment in full is due at the time services are rendered. All balances over 60 days past due will be subject to interest at the rate of 1.5% per month, or may be charged in full to my credit card. If the account is turned over to collection, I agree to pay all costs of collection, including attorney's fees.

Privacy: I have read, and if I choose, have received a copy of the Boulder Holistic Dentistry privacy policy.

Responsible Party ____ Date ___________________