

**BOULDER HOLISTIC DENTISTRY**

**FOR CHILDREN 12 AND UNDER**

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Parents' Name(s) \_\_\_\_\_ Home Phone \_\_\_\_\_

Home Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

City \_\_\_\_\_ zip \_\_\_\_\_ Work Phone \_\_\_\_\_

Workplace \_\_\_\_\_ E-mail \_\_\_\_\_

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

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, Master Card, Discover, 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** \_\_\_\_\_ **Employer** \_\_\_\_\_

**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 Dr. Koral and Dr. Mustian 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 received a copy of the Boulder Holistic Dentistry privacy policy.

**Responsible Party** \_\_\_\_\_ **Date** \_\_\_\_\_