



Pediatric Dentistry of Nanuet, PLLC
55 Old Nyack Turnpike Suite 109, 111 Nanuet, NY 10954
Phone: (845) 507-0100 Fax: (845) 507-0110
www.nanuetpd.com

PATIENT REGISTRATION

Date _____

1. Tell Us About Your Child

Child's First Name _____ Middle Initial _____ Last Name _____

Nickname (if any) _____ Date of Birth _____ Male Female

What are your child interests/hobbies?

Social Security # _____ Home Phone _____

Home Address _____

City _____ State _____ ZIP _____

Email _____

2. Mother's/Guardian's Information

Name: _____

Birth Date: _____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

Employer: _____

Email: _____

3. Father's/Guardian's Information

Name: _____

Birth Date: _____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

Employer: _____

Email: _____

4. Who Is Accompanying the Child Today?

Name: _____

Relationship: _____

Do you have legal custody of this child?

Yes No

5. Responsible Party Information

Name: _____

Birth Date: _____

Home Phone: _____

Cell Phone: _____

Address: _____

City: _____

State: _____ Zip: _____

6. Primary Dental Insurance

Insurance Company Name: _____

Insurance Company Address: _____

Group # (Plan, Local, or Policy#): _____

Policy Owner's Name: _____

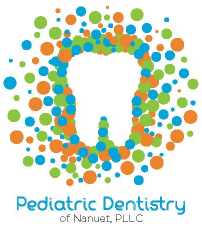
Social Security #: _____

Relationship to Patient _____

Policy Owner's Birth Date _____

Policy Owner's Employer _____

How did you hear about our office? Or who may we thank for the referral?



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PATIENT MEDICAL HISTORY

Patient's Name _____ Birth Date _____

	YES	NO		YES	NO
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac, Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged Bleeding When	<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusion, Date	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Metallic Implant	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Is the patient	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sore, Fever Blister	<input type="checkbox"/>	<input type="checkbox"/>	Puberty/Growth	<input type="checkbox"/>	<input type="checkbox"/>
Drug/Food Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>



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Patient's Name _____ Birth Date _____

Any allergy to Medications/Food(s):

Is there any other health information that should be known?

Is the patient taking any medications? Yes No If yes, please list the medications and reasons:

Has the patient recently been under the care of a physician or had a serious illness or operation in the last 5 years?

Yes No If Yes, please explain

Name & Phone Number of the patient's Physician:

Is this your child's first dental visit? Yes No

Last Dental Visit: _____ Dentist's Name & Phone Number:

Does the patient have a specific dental problem that needs attention? Yes No

If yes, please explain:

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental service my child may need.

Signature of Parent / Guardian

Date

Relationship to Patient



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OFFICE POLICIES

CANCELLATION POLICY: Any cancelled appointments with less than **24 hours' notice** from the scheduled appointment time is subject to a \$25.00 charge per patient. For example, if an appointment is scheduled with Dr. at 10:00AM and the appointment is cancelled at 3:00PM the day before, this is defined as a "cancelled appointment".

Pediatric Dentistry of Nanuet does not double-book appointments; hence, our office only schedules one appointment per allotted half-hour. Therefore, if there are any cancelled appointments, our office would like to contact other patients who need our care. Any siblings that are booked together are considered two appointments (hence, a one hour appointment). If our office schedules a set of siblings together and there is one cancellation, we will not be able to book any siblings together in the future on the same day. Dr. respects the valued time while he is treating his patients and in turn would appreciate for his time to be respected.

CONFIRMATION POLICY: All appointments at Pediatric Dentistry of Nanuet require a **CONFIRMATION** (phone call, email or message on the office answering machine). Our office will attempt to contact the child's parent/guardian the day prior to your scheduled appointment. If we do not reach you, we will try contacting you again before our office is closed. At this time, we require a confirmation for your appointment at (845) 507-0100. Feel free to email us at office@nanuetpd.com. Please leave a message on our answering machine after business hours. You may also call us at any time to confirm your appointment.

FINANCIAL POLICY:

PATIENTS WITH INSURANCE COVERAGE: Pediatric Dentistry of Nanuet obtains an insurance verification for all patients. For any treatment performed, a pre-estimate based on your insurance benefits will be provided to help you obtain the appropriate benefit from insurance carrier. We bill your insurance carrier as a courtesy to you. However, you are responsible for the payments of the account. Any portions of the bill that are not paid by the insurance company are the responsibility of the parent/guardian. Sometimes there is a co-payment required by you as per your insurance agreement. Even if you have double insurance coverage (this is possible if you and your spouse both have insurance), there still may be a portion that will be your responsibility. If you are having treatment over a period of time, payment is due when services are rendered.

PATIENTS WITHOUT INSURANCE COVERAGE: Patients without insurance coverage are required to pay for services when they are rendered.

ADDITIONAL TERMS: For your convenience, we accept Visa, MasterCard, Check and Cash payments. There will be a charge for any duplication of X-Rays. Depending on the X-Ray(s) in question a charge between \$5.00- \$25.00 will be administered. Patients are not authorized to remove the originals from the premises. Any checks that are returned are subject to a \$25.00 charge. In addition, any other bank fees that are incurred are the responsibility of the parent/guardian. If there are any balances on the patient account, no appointments will be scheduled. Accounts unpaid after 30 days from the date of billing are subject to a finance charge at the rate of $\frac{1}{2}\%$ per month (6% per annum). If your account is referred for collection, you will be responsible for collection costs in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees.

We would like to take the opportunity to welcome you to **Pediatric Dentistry of Nanuet**, and assure you that we will do our utmost to provide you with the best care possible!

I HAVE READ AND UNDERSTAND THE CANCELLATION, CONFIRMATION AND FINANCIAL POLICIES OF PEDIATRIC DENTISTRY OF NANUET.

Signature of Parent / Guardian

Date