Kiamesha McClellan, D.D.S.

2200 Morriss Rd., Suite 150
Flower Mound, TX 75028
Phone: 972-539-4290
Fax: 972-355-1736

PEDIATRIC PATIENT REGISTRATION

PATIENT INFORMATION:

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ State _____ Zip _____

Home #_____ Guardian Contact Info - Relationship: _____ #_____

Birthdate_____ Social Security #_____

Age _____ Sex (Please Circle) Male Female

RESONSIBLE PARTY – HOLDER OF INSURANCE POLICY:

Last Name _____ First Name _____ M.I. _____

Address _____

City _____ State _____ Zip _____

Home #_____ Cell#_____ Work# _____

Employer_____ Social Security #_____

Birthdate _____ Sex (Please Circle) Male Female

Primary Insurance Company _____ Phone# _____

Group # _____ ID# _____

SECOND PARENT/GUARDIAN/EMERGENCY CONTACT INFORMATION:

Last Name _____ First Name _____ M.I. _____

Home #_____ Cell#_____ Work# _____

Employer_____ Social Security #_____

AS A COURTESY TO YOU, WE WILL FILE YOUR CLAIMS WITH YOUR INSURANCE COMPANY. HOWEVER, IT IS YOUR RESPONSIBILITY TO MAKE SURE THEY PAY YOUR BILL. IF THEY DO NOT PAY WITHIN 90 DAYS OF SERVICES RENDERED, IT THEN BECOMES YOUR RESPONSIBILITY TO PAY YOUR BILL AND HAVE THE INSURANCE COMPANY REIMBURSE YOU DIRECTLY.

ALL PAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, AND CARE CREDIT.

_____ _____

Signature of patient or responsible party Date

PEDIATRIC MEDICAL AND DENTAL HEALTH HISTORY

KIAMESHA MCCLELLAN, D.D.S.

2200 MORRISS RD., SUITE 150
FLOWER MOUND, TX 75028
PHONE (972) 539-4290

CHILD'S NAME _____ DATE OF BIRTH _____
FATHER'S NAME _____ MOTHER'S NAME _____
NO. OF SIBLINGS _____ CHILD'S FAVORITE HOBBY _____
ANY PETS _____ CHILD'S FAVORITE SPORT _____
PHYSICIAN'S NAME _____ ADDRESS _____
REASON FOR VISIT _____
HOW DID YOU HEAR ABOUT OUR OFFICE? _____ E-mail:

MEDICAL HISTORY

DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS?	YES	NO
1. RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE		
2. CONGENTITAL HEART DISEASE OR HEART MURMUR		
3. ALLERGIES: A) FOOD, DUST, ETC. B) DRUG, (i.e.: Penicillin) C) UNKOWN		
4. ASTHMA OR HAY FEVER		
5. ARTHRITIS OR RHEUMATISM (PAINFUL SWOLLEN JOINTS)		
6. DIABETES/BLOOD SUGAR PROBLEM		
7. ANY PROLONGED BLEEDING OR BRUISES EASILY		
8. KIDNEY OR BLADDER PROBLEMS		
9. ANEMIA OR BLOOD DISORDERS		
10. TUBERCULOSIS OR PNEUMONIA		
11. LIVER PROBLEM, JAUNDICE OR HEPATITIS		
12. GLANDULAR OR HORMONAL PROBLEMS		
13. ACCIDENTS OR SEVERE INFECTIONS		
14. CONVULSION, SEIZURES, FAINTING OR EPILEPSY		
15. HIGH/LOW BLOOD PRESSURE		
16. SPEECH, LEARNING OR HEARING DISORDERS		
17. CHILDHOOD ILLNESSES		
18. IMMUNIZATIONS ARE CURRENT		
19. OTHER, IF SO EXPLAIN		
IF ANY YES ANSWERS, PLEASE EXPLAIN		

DENTAL HISTORY

	YES	NO
1. DATE OF LAST DENTAL VISIT		
2. WHAT TREATMENT WAS RECEIVED?		
3. ANY PREVIOUS UNHAPPY MEDICAL OR DENTAL VISITS?		
4. HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS?		
5. ANY INJURIES TO MOUTH, TEETH, HEAD?		
6. ANY MOUTH HABITS: THUMBSUCKING, NAIL BITING, MOUTH BREATHING, ETC.?		
7. ANY LOST TEETH?		
8. DOES YOUR CHILD BRUSH DAILY?		
9. DO YOU ASSIST CHILD WITH BRUSHING?		
10. HOW OFTEN?		
11. IS DENTAL FLOSS USED?		
12. ARE DISCOLORING TABLETS USED?		
13. HOW DOES YOUR CHILD RECEIVE FLUORIDE? ___WATER ___TOOTHPASTE ___TABLET ___DENTIST ___VITAMIN ___NONE ___OTHER		
14. CHILD'S ATTITUDE TOWARD DENTISTRY:		
15. ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS?		

I hereby certify the foregoing information is true and correct, because _____ is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be completed Authorization is hereby granted as such. Furthermore, I will be responisible for any professional fees incurred for dental services to my child.

Signed _____ **Date** _____

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FINANCIAL POLICY

We would like to take this time to say thank you for allowing us the opportunity to provide for all of your dental needs. We are committed to your treatment being the best possible. We hope that you will find our office staff to be caring, considerate, and professional. If any problems should arise, please feel free to bring it to our attention. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

- Patient's balance is due at the time of service unless prior financial arrangements have been made.
- Full payment is due if insurance cannot be verified.
- We accept cash, checks, Visa, MasterCard, Amex, and Discover.
- We offer an extended payment plan with prior credit approval through Care Credit.
- There is a cancellation fee of $50.00 for any broken appointment without a 24hr notice.

INSURANCE

We will gladly process your insurance claims on your behalf. This is a courtesy we extend to you to help keep the cost of quality dental care affordable. Payment of your estimated cost of treatment is due at the time of service. The estimates obtained in this office are subject to final approval by your insurance company, therefore the amount due is subject to change. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We fully expect the patient to be knowledgeable of the benefits covered by their policy. If your insurance company has not paid your account in full within 90 days, you will be responsible for paying the balance and then getting reimbursed from your insurance company.

Usual and Customary Rates.

Our practice is committed to providing the best treatment for our patients and we charge what are usual and customary fees for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____

Signature of Patient or Responsible Party Date

_____

I.D./Driver's License State and Number