REGISTRATION FORM FOR KATAHDIN PEDIATRIC DENTISTRY **Date: _____**

Patient Name: _____ M: __F: __ Preferred Name: _____DOB: _____

Primary Mailing Address: _____ City: _____State: __ Zip: _____

Preferred Home E-mail Address: _____

How Did You Hear About Us? _____

Previous/Other Dentist & Phone: _____ Primary Care Physician & Phone: _____

Are parents: Married? ____ Separated? ____ Divorced? ____ Widowed? _____ Sharing Custody? ___ Sole Custody? * ___

Parent most likely to bring child to visit: Mom? ____ Dad? ____ Both? _____ Foster Parent _____

Preferred place to send bill: Child's Home Address _____ Dad _____ Mom _____ Both _____Court Ordered? ** _____

Parent to receive text reminder about upcoming appointments? Dad _____ Mom _____ Foster Parent/Other _____

Parent to receive email reminder about upcoming appointments? Dad _____ Mom _____ Foster Parent/Other _____

* If one parent (who_____) holds sole custody of child – is this court ordered? YES___NO___
*** If yes, please bring copy of court order to New Patient visit*

Responsible Party: _____ SS#: _____ DOB: _____

Relationship: _____ Mailing Address (*if different from child*): _____

City: _____ State: ___ Zip: _____ Employer: _____

Address: _____ Cell Phone: _____

Secondary Phone: _____ Email: _____

Policy Holder: _____ SS#: _____ DOB: _____

Relationship: _____ Mailing Address (*if different from child*): _____

City: _____ State: ___ Zip: _____ Employer: _____

Address: _____ Cell Phone: _____

Secondary Phone: _____ Email: _____

Primary Dental Insurance: _____ Subscriber: _____

Policy ID: _____ Policy Group: _____ Phone: _____

Claims Mailing Address: _____

Secondary Dental Insurance: _____ Subscriber: _____

Policy ID: _____ Policy Group: _____Phone:_____

Claims Mailing Address: _____

Is patient covered by MaineCare or any other State of Maine assistance program? YES ___NO___

MaineCare ID#: _____ Effective Date: _____

If status pending MaineCare or other assistance program – please explain: _____

Has patient had MaineCare or any other Maine assistance program in the past twelve months? (if Yes, Dates: _____)

Additional Notes? (i.e. If Foster Care of child is involved, please note Name, Date of Birth & Contact information for Foster Parent.)

_____

Received by Staff Member: _____ Date: _____

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Patient Informed Consent Agreement

GENERAL CONSENT TO TREATMENT AT KATAHDIN PEDIATRIC DENTISTRY

I voluntarily consent to such routine dental procedures, diagnostic and treatment, as determined by my child's oral health provider and his/her designees to be necessary and desirable based on his/her exercise of professional judgment for my child.

My child's treatment or condition may be photographed or electronically recorded in order to provide, coordinate, or manage my child's care. A photograph of me and/or my child may be included in the record for identification purposes. I accept to share any images electronically for diagnostic, and education.

I understand that my child's oral health provider will explain to me the purpose of, benefits, and the usual and most frequent risks and hazards involved in the diagnosis and treatment of any condition or injury, as well as alternative courses of treatment. I further understand that I have the right to refuse any suggested examination or treatment on behalf of my child.

I am aware that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me as to the result of my child's examination and treatment.

GUARANTEE OF PAYMENT AND ASSIGNMENT OF BENEFITS

I authorize and direct payments to Katahdin Pediatric Dentistry by any applicable insurer or other payor or dental benefits and other sums otherwise payable by me, but not to exceed the regular charges for the care provided to my child. I am financially responsible to Katahdin Pediatric Dentistry for any charges not paid by other payors (including deductibles, co-payments, and non-covered services.)

I understand that my Insurance coverage is only an approximation based on coverage that I choose and that it is my responsibility to know the details of my insurance plan relative to covered or non-covered services.

In the event that the designated insurance company does not pay for the service provided by the dental professional, the responsible party listed on the account will be held responsible for the payment in full. Standard office billing practices will apply thereafter. Our insurance team will aid in the processing of the initial claim, any dispute over a claim will be the responsibility of the guarantors and patient's responsible party.

I understand that Katahdin Pediatric Dentistry will not knowingly charge or accept payment for care that has caused my child serious harm resulting from preventable mistakes and adverse events as defined by State of Maine law.

AGREEMENT

I understand the recommended treatment for my conditions, the risks of such treatment, any alternatives and their risks as well as the consequences of doing nothing. All fee(s) have been explained. All of my questions have been answered and I have not been given any guarantees.

I understand that insurance coverage is only an estimation. Guarantor is responsible for all treatment not covered by insurance.

_____ _____

Patient **Witness**