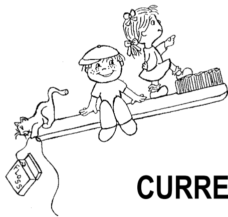

REGISTRATION FORM

Melissa A. Morrow, D.D.S

Patient
Full Name: ____________________ Birth Date: ____________

CURRENT PATIENT INFORMATION

PERSON(s) with whom patient resides: _____Parent _____Guardian

Name(s) ____________________

FATHER'S NAME ____________________

Address ____________________

____

Home Phone ____________ Cell____________

Email address____________________

Birthdate ____________ Marital Status____________

Occupation/Employer ____________________

Business Phone____________ Social Security #____________

Drivers License # ____________________

Dental Insurance through **Father's** employer YES NO

If YES, Insurance Co. Name ____________________

Group # ____________ Phone # ____________

MOTHER'S NAME ____________________

Address (**if other than above**) ____________________

____

Home Phone ____________ Cell____________

Email address____________________

Birthdate ____________ Marital Status____________

Occupation/Employer ____________________

Business Phone____________ Social Security #____________

Drivers License # ____________________

Dental Insurance through **Mother's** employer YES NO

If YES, Insurance Co. Name ____________________

Group # ____________ Phone # ____________

Signature____________________**Date**____________

Dental Insurance through **patient/child** *(Healthy Kids or My Child)* YES NO

SS#____________________Sub ID#____________________

POLICIES

PAYMENT

The person who accompanies the patient to the dental office and/or signs the consent is responsible for the account.

Patients who are NOT covered by dental insurance: All charges are expected to be paid in full at the time the dental services are rendered. Payment can be made by cash, check, Visa or Master Card. If you ever have any questions about fees, please ask.

Patients who are covered by a dental insurance carrier: Parents/Patients are requested to be prepared to pay their estimated portion of the dental services (co-pay) on the day the services are rendered for the patient. Aetna & BCBS patient services are expected to paid for in full at the time of treatment.

The dental office will complete our portion of any insurance form that is provided by the parent/patient, and will forward the form to the insurance carrier for payment. The parent/patient, however, is responsible for the total fee and will be expected to make up for any deficiencies in the insurance coverage.
Interest may be charged on any estimated patient portions.

COLLECTION

In the event that your account becomes past due and is turned over for any collection action, there will be an automatic charge of $30.00. This is in addition to any and all collection costs incurred by this office.

FAILED APPOINTMENTS

When an appointment time is reserved for you or your child, it is reserved for you alone. **WE MUST HAVE 24 HOURS NOTICE IF YOU ARE UNABLE TO KEEP A SCHEDULED APPOINTMENT.** No charge will be made for a missed appointment, if this request is honored. Should an appointment be missed without appropriate cancellation notice, there will be a missed appointment charge of $50.00. Missed appointment fees will increase in increments of $50.00 for each additional appointment missed by any member of your family. You are responsible for this fee. The fee must be paid within 30 days and prior to any other scheduled appointments. The office telephone is answered 24 hours a day should you need to leave a message at night or on weekends. If we find that there is a continued problem with missed appointments, we may need to re-evaluate our patient/doctor relationship with your family.

I UNDERSTAND and AGREE TO ABIDE by the ABOVE POLICIES of Melissa A. Morrow, D.D.S.

Signature ____________________ **Date** ____________________

CONSENT for TREATMENT

I hereby authorize dental treatment for ____________________. This authorization includes procedures which are reasonable and customary for pediatric dentistry and deemed necessary by Dr. Melissa A Morrow. Consultations are customary prior to treatment. **I also agree to pay the fees that are set for all treatment according to the payment policy set forth above.**

Signature ____________________ **Date** ____________________

SIGNATURE on FILE

Do you have insurance to cover any dental charges? _____YES _____NO, if yes please sign below.

Patient's Name ____________________
I hereby authorize payment directly to Melissa A. Morrow, D.D.S. of the dental benefits otherwise payable to me.

Signature ____________________ **Date** ____________________

Melissa A. Morrow, D.D.S., attending Dentist, is authorized to provide any insurance company(s), claim administrator(s) and/or consulting health care professionals, information concerning health care, advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contract, enforce at time of treatment. I know I have a right to receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Signature ____________________ **Date**____________________