Stanley F. Kayes, DDS

CHILDREN'S REGISTRATION FORM

Patient's Name______________________________________ Date of Birth_______________________

Address____City/State/Zip______________________
Parents'
Names____

Parents' Employers____

Patient's School_____________________________ Patient's Hobbies or Interests_______________________________

Person Responsible For Account________________________________ Social Security Number of Account Holder_________________________

Child's physician _____________________________________ Phone ___________________________

Person to Contact In an Emergency_____________________________________ Telephone______________________
(if parents are unavailable)

Additional address (of non custodial parent)____

How did you find out about this office? ____

COMMUNICATION INFORMATION (answer any that apply)

Home Phone___________________ Work Phone___________________ Pager____________________

Cell Phone_____________________ E mail________________________ Fax _____________________

What is the best way to reach you
in the daytime? _______________________________In the evening?____________________________

List any special instructions for relaying messages to you:____
(such as different sleeping schedules due to shift work, best times to call, etc.)

Please authorize below any ways that we may leave messages regarding your child's dental treatment or account or insurance information. Answer yes or no for each that applies.
On your home answering machine _____________ By E mail_______________________________
On your office voice mail________________________ By office fax____________________________
With a designated relative or friend (please list)____
By designated fax number_________________________

INSURANCE INFORMATION

Name of Insured_____________________________ Insured's Birthdate_________________________

Ins.Company____________________ Group #______________ Employee Certificate #_____________________

Insurance Address____Phone__________________

Secondary Dental Insurance Information

Name of Insured_____________________________ Insured's Birthdate_________________________

Ins. Company___________________Group #________________ Employee Certificate #____________________

Insurance Address____**Phone**__________________

INSURANCE AUTHORIZATION AND RELEASE

I authorize the dentist to release information and records of any treatment rendered to my child to my insurance company or to other health care providers, including my child's physician, any specialists to whom he or she is referred, laboratories, or hospitals __________(initial)

I authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me ______ (initial)

I understand that my dental insurance may pay less than the actual bill for service and that this office does not guarantee any payment from my insurance company. I understand that it is my responsibility to know my insurance company's regulations regarding the frequency allowed for dental exam and cleaning appointments, and their rules regarding substitution of alternative dental treatments. I agree that I am responsible for payment to this office for any amount not covered by insurance_____(initial)

Signature_______________________________________ Date_________________________

FINANCIAL POLICY/ CANCELLATION POLICY

All checks returned by the bank are subject to a fee of $20.00.

Accounts that are delinquent over thirty days will incur a service charge of 1% per month (12% annual percentage rate).

In case of default of account for present and future balances, patient or person responsible for account agrees to pay collection costs, including attorney's fees, incurred in attempt to collect balance due.

Appointment cancellations and no shows: We will attempt to contact you to confirm your child's dental appointments. If you can not be contacted after several attempts to confirm appointment, the appointment time may be released to another patient on a waiting list. If after appointment confirmation is made, you do not show for the appointment or cancel with less than twenty-four hours notice, a cancellation fee may be assessed.

I understand the financial and cancellation policies at this office. I understand that I am responsible for all services rendered to my child. If another person is responsible for this account, or if responsible party changes, I understand that it is my responsibility to notify this office.

Signature____ Date__________________________