CHILD'S REGISTRATION FORM

Child's Name ____________________

Nickname ____________________ Age ________ Sex M / F

Date of Birth ______/______/______ Today's Date ______/______/______

Child's Physician ____________________

Name of School Attending ____________________ Email Address ____________________

Is child taking any medications? .... Yes No

Please list ____________________

Is the child sensitive or allergic to anything? .... Yes No

If so, please specify: ____________________

Has child experienced any unfavorable reaction from any previous dental or medical care? .... Yes No

Has child lived or been living in an area where water supply was fluoridated? .... Yes No

History of heart trouble, rheumatic fever, epilepsy, HIV, Tuberculosis, diabetes, bleeding, or mental disorders? If yes, underline. .... Yes No

Special needs due to mental retardation, Down's Syndrome, Cerebral Palsy, ADHD, bi-polar disorder, autism? .... Yes No

Is child in good health? .... Yes No

Adolescent females – pregnant? .... Yes No

If so, how many months? ____________________

Please use reverse side for any additional information regarding child's history.

Parent or Guardian ____________________ Date of Birth ______/______/______

Social Security # ______/______/______ Drivers License # ____________________

Residence Address ____________________ Phone(______) ____________________

Apt # ________ City ____________________ State ____________________ Zip ____________________

Employer ____________________

Business Address ____________________ Phone(______) ____________________

City ____________________ State ____________________ Zip ____________________

Referred by ____________________

Will you be using insurance? ☐ Yes ☐ No

Do you have more than one insurance? ☐ Yes ☐ No Explain ____________________

RESPONSIBLE PARTY INFORMATION (If different from front)

Responsible Party Name ______________________________

Relationship to Patient ______________________________

Date of Birth ______/______/______

Social Security #______-______-______ Drivers License #______________________

Home Address ______________________________

Apt # ________ City ______________ State ____________ Zip __________

Employer ______________________________

Business Address ______________________________

City ______________________ State ____________ Zip __________

Business Phone (______)______________

Emergency Contact______________Phone (______)____________ Relationship to Patient ________

Additional Information ______________________________

To the best of my knowledge, these questions have been answered accurately. It is my responsibility to inform the dental office of any changes in medical status.

Signature ______________________________ Date ______________

* *

I, ______________________________, give consent for ______________________________

(Parent or Gurardian) Patient

to receive dental treatment and authorize Dr. Tennison to provide these diagnostic and preventative services: a dental examination, dental xrays, teeth cleaning, fluoride treatment or sealants.

Signature ______________________________ Date ______________

EDDIE G. TENNISON, D.D.S.

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All patients must complete our "Patient Information Form" before seeing the doctor.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

- WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AMERICAN EXPRESS, DISCOVER.

ADULT PATIENTS
Adult patients are responsible for **full payment** at time of service.

MINORS ACCOMPANIED BY AN ADULT
The adult accompanying a minor, and his/her parents (or guardians), are responsible for **full payment** at the time of service.

UNACCOMPANIED MINORS
The parents (or guardians) are responsible for **full payment**. Non-emergency treatment will be denied unless charges have been paid in full at time of service.

REGARDING INSURANCE
If you have insurance, we will help you receive maximum benefits.

We MAY accept your insurance if you obtain approval from our office staff prior to the date of service. If we accept your insurance, you must pay your estimated portion. If your insurance company has not paid the FULL BALANCE within 45 days, you have 15 days to pay the balance. If your insurance company pays more than the balance due, we will send a refund check to you immediately.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We are NOT a party to this contract, in most cases. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, "usual and customary" charges, etc., other than to supply factual information as necessary. You are responsible for the timely payment of your account.

MISSED APPOINTMENTS
Unless canceled 24 hours in advance, our policy is to charge for missed appointments at the rate of $15 per 15 minutes of appointment time.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature ______________________________ Date ____________

Eddie G. Tennison D.D.S.
2117 N. Mays
Round Rock, TX 78664
(512) 244-1221

APPOINTMENT POLICY
PLEASE READ AND SIGN

We are happy to provide services for your child. However we are unable to provide for patients who do not keep scheduled appointments. It generally takes our staff 48 hours at least to fill a cancelled appointment. Patients who call to reschedule appointments with at least two days notice can usually be accommodated without a problem. Short notice cancellations and patients who "no show" appointments may result in permanent discontinuation of services. This is a private dental office and we simply cannot afford to provide for folks who do not take their appointments seriously. We do make exceptions in situations of unavoidable circumstances (like traffic accidents and sudden serious illness). However appointments broken without at least 24 hours notice will almost always result in a broken appointment fee or discontinuation. Please understand that we must keep the doctor and hygienist completely scheduled at all times. We are not a government funded clinic and must generate a profit to pay our employees and stay in business. Your cooperation in this matter is greatly appreciated.

In general it is our policy to confirm all appointments 48 hours in advance. If we leave a message at your residence or job, please Do return our phone call to confirm or change the appointment. If the office staff does not answer when you call, there is an answering machine at 244-1221 to leave a message. If we do not hear from you by the day before the scheduled appointment, we will attempt to give your appointment to another patient. It may be difficult for you to reschedule without a substantial delay. We want to work with you if you have problems keeping a scheduled appointment. But we need reasonable notice to change appointments and you have to call. Please give us all your phone numbers including cell phone and pager if you have them. We need to reach you during our business hours. Remember that we don't mind if you break an appointment. We just want to know in advance so that we can keep our schedule full.

____
Signature

Eddie G. Tennison, DDS
2021 North Mays, Ste 1200
Round Rock, TX 78664
Phone: (512) 244-1221

Acknowledgement of Receipt of Notice of Privacy Practices

I, ______________________________________ have received a copy of the
(Name of Patient)

Notice of Privacy Practices for Eddie Tennison, DDS.

____
(Signature of Patient or Responsible Party)

Staff Will Fill Out This Section If Patient's Signature Is Not Obtained

Our office made a good faith effort to obtain Acknowledgement of Receipt of our notice of Privacy Practices, but it could not be obtained for the following reason:

____ Patient refused to sign.

____ Emergency situation kept us from obtaining the Patient's signature

____ Language barriers kept us from obtaining the Patient's signature.

____ Other ____

Eddie G. Tennison, DDS
2021 N Mays St, Ste 1200
Round Rock, Texas 78664

Medical Information Release Form

(HIPAA Release Form)

Name: ________________________________ **Date of Birth:** _____/_____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse____

[ ] Child(ren)_____________________________________

[ ] Other____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] ____

The best time to reach me is (*day*)__________________ between (*time*)__________

Signed: ____________________________________ Date: ____/____/_____

Witness:____________________________________ Date: ____/____/_____