

Paul S. Busch, D.D.S., P.C.
Gentle Dentistry
530 Nichols Road
Kalamazoo, MI 49006

Child's Registration Form

Child's Name _____ Date of Birth _____

Street Address _____ City _____

State _____ Zip _____ Home Phone _____

Father's Name _____ Work Phone _____

Father Employed By _____

Mother's Name _____ Work Phone _____

Mother Employed By _____

Dental Insurance Information

Name of Dental Insurance Carrier _____

Parent Insured _____ Employer _____

Employer Address _____

Social Security Number _____ Date of Birth _____

Dental History

Date of last visit to dentist _____

Has child complained about dental problems? Yes No

Does your child brush teeth daily? Yes No

Do you assist child with tooth brushing? Yes No

Any unhappy dental experience? Yes No

Child Registration Form Continued

Any injuries to mouth, teeth, head?	Yes	No
Any habits (thumb sucking, nail biting, nursing bottle habits, mouth breathing pacifier, etc)	Yes	No
Any unusual speech habits?	Yes	No
Any lost teeth?	Yes	No
Have orthodontic appliances ever been worn or are currently being worn?	Yes	No

Health History

Child's Physician _____ Address _____

Physician's Phone Number _____ Date of last physical _____

Results _____

Is child currently under care of physician?	Yes	No
Does child have good physical coordination?	Yes	No
Is child receiving any medication now?	Yes	No
Is there any excessive bleeding when cut?	Yes	No
Has child ever been hospitalized?	Yes	No
Any allergies? (penicillin, other drugs, pollen, food animals, dust, insect bites, Novocain, etc)	Yes	No

Has child had any history or difficulty with any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Chronic sinus	<input type="checkbox"/> Hearing	<input type="checkbox"/> Mastoid	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Asthma	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart	<input type="checkbox"/> Measles	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Other
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver	<input type="checkbox"/> Mumps	<input type="checkbox"/> HIV/AIDS
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Fainting	<input type="checkbox"/> Malignancies	<input type="checkbox"/> Rheumatic Fever	

Please describe any current medical treatment including drugs, pending surgeries, recent injuries or any other information I should be aware of that we have not discussed.

Parent signature _____

Date _____

Dr. Paul S. Busch, D.D.S., P.C.

We welcome you as a patient and appreciate the opportunity to provide you with the best care that is available.

Thank you for choosing us as your dental care provider. Our purpose is to enable our patients to achieve excellence in dental health and freedom from head and neck pain. We will make every effort to provide gentle dentistry in a caring and pleasant atmosphere.

Our Office Policy

We require each patient to read and sign our office policy prior to any treatment. All patients must complete our "Patient Information Forms" before being seen by the doctor.

Appointments:

Unless notified at least 24 hours in advance, our policy is to charge for missed appointments. Cancellations left on the answering machine must also be 24 hours in advance. This courtesy allows us to give the appointment times to patients who are waiting.

Payment Methods:

Full payment is expected at the time of service. We accept cash check, Visa and Master card; we also accept debit/check cards. We also offer Care Credit and Dental Fee Plan. These plans require prior approval, and offer no interest for one full year depending on balance, and type of plan enrolled on.

Minor Patients:

Minor patients must be accompanied by their parent or guardian. Unaccompanied minors may be denied treatment unless prior arrangements have been made.

Insurance:

We may accept assignment of insurance benefits providing all paperwork and necessary information is complete. However, we do require that deductibles and co-payments be paid at the time of service. Your insurance policy is a contract between you, your employer, and the insurance company. If any services are rejected, you are responsible for any fees that your insurance company includes. We allow 45 days grace period for all insurance claim payments to arrive. If no payments have been made by then, the balance may be transferred to you. All balances are due upon receipt and are subject to a monthly billing charge if more than 30 days overdue.

I have read the office policy, understand and agree with it.

Signature

Date

Thanks, Paul S. Busch, D.D.S.