DR. TREY'S CHILDREN'S DENTISTRY

Thank you for taking the time to complete our new patient paperwork. If you have any questions, please just ask.

ABOUT THE PATIENT(S)

Patient 1's Name: _____	**Pt 1** Likes to Be Called: _____
If Applicable, Medicaid #: _____	Male / Female • DOB _____
Patient 2's Name: _____	**Pt 2** Likes to Be Called: _____
If Applicable, Medicaid #: _____	Male / Female • DOB _____
Patient 3's Name: _____	**Pt 3** Likes to Be Called: _____
If Applicable, Medicaid #: _____	Male / Female • DOB _____
Patient 4's Name: _____	**Pt 4** Likes to Be Called: _____
If Applicable, Medicaid #: _____	Male / Female • DOB _____

Parents Names:_____**Phone #** _____

Patients' Mailing Address: _____

Patient's Email: _____

RELEASE INFORMATION

I authorize Dr. Trey's Children's Dentistry to release information concerning the patient to those listed below:

____ Myself/My Voicemail Only ____ Those Listed Below

1. Name: _____ Relationship to Patient: _____ Phone #: _____
2. Name: _____ Relationship to Patient: _____ Phone #: _____

DENTAL INSURANCE INFORMATION

Name of Insured: _____	Insured's Employer: _____
Insured's DOB: _____	Insurance Company:_____
Insured's SS #: _____	ID #: _____
Insured's Address: _____ *(if different from above)*	Group #: _____

GETTING TO KNOW YOU

How did you hear about us? Phonebook • Internet • Dr. Trey's Children's Dentistry Website • ES Parent Mag • Doctor/Dentist/Family/Friend:_____• Other_____

CONSENT TO ALL OFFICE POLICIES

My signature below indicates the following:

1. I have received, read and understand all new patient paperwork, including but not limited to our financial, treatment, "separation" and cancellation policies, and the release of certain information under HIPAA. Additionally, all questions that I may have regarding these policies have been asked and answered to my satisfaction.

2. I hereby authorize Dr. Fellers and staff to take x-rays, study models, photos and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.

3. Upon such diagnosis, I authorize the doctor and/or staff to perform all recommended treatment.

4. I agree to the use of anesthetics, nitrous oxide and any other behavioral management techniques that are deemed necessary by the doctor to treat the patient with his/her best interests in mind.

5. **Our office is so excited to welcome you to our office and since there are so many children wanting to get an appointment, we are going to be very strict on our cancellation policy. We ask that you give us at least 24 hour notice when cancelling. If you fail to do this we will have to collect a fee of $25.00 before you will be able to reschedule your child's appointment. We are privileged to have so many patients wanting to get in to see us the we can't allow "no shows" on our schedule. Thank you for understanding.**

_____ _____ _____

Print Your Name & Relationship to Patient **Your Signature** **Date**

OVER PLEASE