



PC

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Pediatric Dentistry

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Patient Registration and Confidential Health History.
 Please complete the following.

1
Step *Tell Us About Your Child...*

		Today's Date	
Child's Name		Nickname	
Child's Birthdate	Age	<input type="checkbox"/> Boy <input type="checkbox"/> Girl	Grade
School		Child's Social Security #	
Address		City	State Zip
Child's Home Phone Number			

2
Step *Who is Accompanying the Child Today?*

Name	Relation
Do you have legal custody of the child? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Emergency Contact (name and phone number)	

3
Step *Insurance Information*

Dental Insurance Company	Group Number	
Insurance Company Address	Insurance Company Phone	
Insured Employee Name	Relationship to Child	
Birthdate	Insured Employee SS#	Employer

4
Step *Parents' Information*

Child's Mother

Name	Birthdate
Address	How Long?
Employer	How Long?
Occupation	Social Security Number
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other: _____	
Home Phone	Business Phone Ext.
Wireless Phone	Driver Licence Number
Email Address	

Child's Father

Name	Birthdate
Address	How Long?
Employer	How Long?
Occupation	Social Security Number
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Other: _____	
Home Phone	Business Phone Ext.
Wireless Phone	Driver Licence Number
Email Address	

5
Step

Getting to Know You

Whom may we thank for this referral?

Your Child's Hobbies and Interests

Do you have other children as patients in our office? Yes No

Their Name(s)

Address City State Zip

6
Step

Emergency Contact Information

Name of an individual you would like us to contact in an emergency?

Address City State Zip

Home Phone # Work Phone # Ext #

Closest Relative NOT living with you?

Address City State Zip

Home Phone # Work Phone # Ext #

7
Step

Please Read, Office Policies and Federal Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (*the amount not covered by insurance*) are due and payable at the time of service.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of a 1.5% per month (*18% per annum*) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay, the reasonable value of said services to said dentist or his assignee at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended, I further agree that the reasonable values of said services shall be as billed unless objected to by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit is instituted hereunder to collect monies owed by me, including interest charges, processing fees or commissions (*up to 50% of principle*) that may be assessed by any collection agency retained to pursue this matter.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, to Dr. Roy H. Rogers.

I certify that I have answered all questions on the form accurately and I hereby agree to abide by the conditions outlined there in.

8
Step

Please Sign Below

Signature of Patient, Parent or Guardian

Date

Relationship to patient