*The Martin Dental Center for Oral Health and Aesthetics*

**New Patient Registration (Child)**

Full Legal Name: _____ Name Preferred_____

Today'sDate_____BirthDate_____

Parent or Guardian's Name _____

Address_____
City_____Zip Code_____
Phone Numbers:
Home_____Work_____Cell_____

Head of Household Social Security#_____ - _____ - _____Required by Dental Insurance Companies

Head of Household's Employer_____

Pediatrician or Family Doctor_____
Parent's Marital Status Married ( ) Single ( ) Divorced ( ) Widowed ( )
If married, spouse's name_____ Is Spouse a patient? Y ( ) N ( )
List any other family members who are patients
_____
Referred by: _____

Do you have dental insurance? _____E-mail address _____

Please check the appropriate answers in the columns provided. YES NO

Has your child ever had any of the following?
Heart Disease_____ ____ ____
Tuberculosis_____ ____ ____
Diabetes_____ ____ ____
Thyroid Problems_____ ____ ____
Hepatitis (Jaundice)_____ ____ ____
High Blood Pressure_____ ____ ____
Stroke or Arteriosclerosis_____ ____ ____
Sexually Transmitted Disease_____ ____ ____
Is your child under the care of a physician for any condition? ____ ____
_____
Has there been any change in your child's health in the last year? ____ ____
_____
Has your child ever been seriously ill _____ ____ ____
Does your child have a heart murmur _____ ____ ____
Is your child taking any medications? Please list below: ____ ____

| Medication | For | Medication | For |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Does your child have a history of any of the following: Please check appropriate column provided

| | YES | NO |
|---|---|---|
| Have an allergy to penicillin, dental anesthetic or any other drug _____ | ____ | ____ |
| Have any problems with prolonged bleeding _____ | ____ | ____ |
| Have a history of surgery or radiation therapy _____ | ____ | ____ |
| Have or carry AIDS_____ | ____ | ____ |
| Have a history of a blood transfusion within the past 5 years___ | ____ | ____ |
| Have a history of seizures or convulsions_____ | ____ | ____ |
| Have any disorder, such as anemia_____ | ____ | ____ |
| Have a toothache_____ | ____ | ____ |
| Require antibiotics before treatment by the dentist _____ | ____ | ____ |

In an effort to control fees, we recognize that one of the best methods is to control costs. We have therefore instituted the following policies as an aid in minimizing our overhead expenses:

1. If it is necessary to change your appointment time, we request that you notify us **during our business hours,** at least 24 hours prior to your appointment. Failure to keep a scheduled appointment without appropriate notification **WILL** result in a **service fee.**
2. Payment is due when services are rendered. Returned checks will be subject to a $25.00 administration fee **and account balances over 60 days will be subject to finance charges of 1.5% per month.**
3. If you have dental insurance we will be happy to assist you in the processing of your claim. Although we accept assignment on preventive and treatment planned dentistry, we ask that all other visits as well as deductibles and co-payments be taken care of at the time of service. As a courtesy to you, we will submit your claim form, but is your responsibility to provide us with correct and up to date information. When there is a delay in receiving payment from the insurance carrier, it is the responsibility of the insured person to investigate the delay. The responsible party will be requested to make full payment when an insurance claim is outstanding beyond 45 days from the date of service.

Thank you for your compliance. We look forward to being of service to you.

Wyman B. Martin, D.D.S., and Staff

I agree to the terms listed, and my consent is given for the performance of necessary dental treatment.

Signature of parent orGuardian_____

# THE MARTIN DENTAL CENTER

45 W. Crossville Rd  Suite 505, Roswell, GA  30075

www.themartindentalcenter.com  T – 770-993-7424  F – 678-461-4436

**Credit Card Authorization Form**

I _____ hereby authorize THE MARTIN DENTAL CENTER to submit claims on my behalf and agree to assign the payment directly to THE MARTIN DENTAL CENTER. I understand that my insurance is an agreement between the insurance company and myself. I further understand that I am responsible for any service fees or balances that may not be covered by my dental benefits plan and any differences resulting from the amount billed and the amount covered by my plan. I authorize the following credit card to be billed for any outstanding balances.

Patient Name: _____

Responsible Party (if different than patient): _____

Please circle credit card: Visa  MasterCard  Amex  Discover  HSA

Phone #:_____E-mail address_____

Card #: _____Exp. Date:_____Security Code_____

Street # _____  Zip Code: _____

Card holder signature: _____

Today's Date: _____

Staff Initials: _____