FRANCO & ASSOCIATES Family & Cosmetic Dentistry

REGISTRATION & HISTORY

DI	E/	SE	PR	INT
PL	EP	19E	PR	

(For Minors)

Name Date of Birth Phone Nickhame Sex: M F Nickhame Sex: M F Home Address City State Zip 2. PARENTS/FAMILY Taffer's Name Date of Birth Marital Status: S M W D Se Place of Business Phone Phone Phone Business Address Phone Phone Phone State Zip Zip Zip ZiA A. PERSON RESPONSIBLE FOR THIS ACCOUNT State Zip Zip Statos of Insurance Policy Holder's Name Policy Holder's DOB Name of Insurance Policy Number Policy Number Policy Holder's Social Security Number Sactiontric Scassociates Dentistry for cha	Biographical Data (Filled out	by parent or guardian)	
NeknameSex: M F	1. PATIENT		
NeknameSex: M F	Name	Date of Birth	Phone
chome Address City State Zip 2. PARENTS/FAMILY 2. PARENTS/FAMILY 2. PARENTS/FAMILY Place of Business Place of Business Business Address Business Address City Date of Birth Marital Status: S M W D Se Place of Business Place of Business Place of Business City Business Address Business Address City State Zip Address State State			
2. PARENTS/FAMILY Father's Name Date of Birth Marial Status: S M W D Se Place of Business Date of Birth Marial Status: S M W D Se Business Address Date of Birth Marial Status: S M W D Se Place of Business Date of Birth Marial Status: S M W D Se Place of Business Date of Birth Marial Status: S M W D Se Place of Business Address Date of Birth Marial Status: S M W D Se Place of Business Address Date of Birth Marial Status: S M W D Se Place of Business Address Date of Birth Marial Status: S M W D Se Place of Business Address Date of Birth Marial Status: S M W D Se Business Address Date of Birth Marial Status: S M W D Se Place of Business Date of Birth Marial Status: S M W D Se Place of Business Date of Birth Marial Status: S M W D Se Business Address Date of Birth Marial Status: S M W D Se Place of Business Date of Birth Marial Status: S M W D Se Place of Business Date of Birth Marial Status: S M W D Se Place of Business Date of Birth Marial Status: S M W D Se Place of Business Date of Birth Marial Status: S M W D Se Place Address Date of Birth Marial Status: S M W D Se Place of Business Address Date Date	Pets, Hobbies		
Father's Name Date of Birth Marital Status: S M W D Se Place of Business Phone Business Address Phone Mother's Name Date of Birth Marital Status: S M W D Se Place of Business Phone Business Address Phone Business Address Phone Brothers/Sisters (names and ages) State 3. LEGAL GUARDIAN (if other than parent) Name Phone Address City State Zip 4. PERSON RESPONSIBLE FOR THIS ACCOUNT 5. INSURANCE (is your child covered by) Social Agency Policy Holder's Name Policy Holder's Name Policy Holder's Name Policy Holder's Social Security Number Signed: X Insured Person * RECORDS RELEASE hereby authorize Franco & Associates Dentistry for charges not paid under this assignment. A copy of this form shall be as atid as the original. * Signed: X Insured Person * RECORDS RELEASE hereby authorize Franco & Associates Dentistry to release to my insurance company any information, including diagnosis and records if treatment concerning my dental care. * Signed: X gan extended payment plan. Any charge carried on the books for 60 days or longer will be ch	Home Address	City	State Zip
Place of Business Phone Business Address	2. PARENTS/FAMILY		
Business Address	Father's Name	Date of Birth	Marital Status: S M W D Se
Business Address	Place of Business		Phone
Mother's Name			
Business Address Brothers/Sisters (names and ages) 3. LEGAL GUARDIAN (if other than parent) Name			Marital Status: S M W D Se
Brothers/Sisters (names and ages) 3. LEGAL GUARDIAN (If other than parent) Name	Place of Business		Phone
3. LEGAL GUARDIAN (If other than parent) NamePhonePhone	Business Address		
Name	Brothers/Sisters (names and ages)		
Address	3. LEGAL GUARDIAN (If other than parent	t)	
	Name		Phone
	Address	City	State Zip
	4. PERSON RESPONSIBLE FOR THIS	ACCOUNT	
Dental Insurance Policy Holder's NamePolicy Holder's DOB Name of Insurance Co Policy Number Policy Number Policy Holder's Social Security Number Signed: X			
Policy Holder's Name Policy Holder's DOB Name of Insurance Co Policy Number Policy Holder's Social Security Number authorize payment of benefits, as determined by my insurance policy, directly to Franco & Associates Dentistry. I understand that I am financially responsible to Franco & Associates Dentistry for charges not paid under this assignment. A copy of this form shall be as raild as the original. Signed: X Insured Person 7. RECORDS RELEASE hereby authorize Franco & Associates Dentistry to release to my insurance company any information, including diagnosis and records of treatment concerning my dental care. Signed: X Patient or Guardian 8. INTEREST CHARGE AND CREDIT POLICY All bills are considered due within 30 days of service. If you cannot pay the balance, please contact our credit department to arrange for an extended payment plan. Any charge carried on the books for 60 days or longer will be charged a fee of 66% a month for an ANIVUAL PERCENTAGE RATE) OF 7.92%, on the unpaid balance. My signature acknowledges that I understand this policy: Signature: X Date: 9. REFERRAL (If you are a new patient) Thank you for selecting our practice. It would be helpful to know why you selected us. Referred by friend/family Referred by Doctor/Dentist Perferred by friend/family Referred by Doctor/Dentist Perferred by friend/family Referred by Doctor/Dentist Patierred by response Ad Pother (specify)	S. INCOMANCE (IS your child covered by)		
Name of Insurance Co			
Policy Number			
Policy Holder's Social Security Number			
ASSIGNMENT OF BENEFITS authorize payment of benefits, as determined by my insurance policy, directly to Franco & Associates Dentistry. I understand that I am financially responsible to Franco & Associates Dentistry for charges not paid under this assignment. A copy of this form shall be as alid as the original. Signed: X			
am Inflancially responsible to Franco & Associates Dentistry for charges not paid under this assignment. A copy of this form shall be as valid as the original. Signed: X	3. ASSIGNMENT OF BENEFITS		
Insured Person Insur	am financially responsible to Franco & Associa valid as the original.	ates Dentistry for charges not paid under this assignme	es Dentistry. I understand that I ent. A copy of this form shall be as
Insured Person Insur		Signed: X	
hereby authorize Franco & Associates Dentistry to release to my insurance company any information, including diagnosis and records of treatment concerning my dental care. Signed: XPatient or Guardian 8. INTEREST CHARGE AND CREDIT POLICY All bills are considered due within 30 days of service. If you cannot pay the balance, please contact our credit department to arrange for an extended payment plan. Any charge carried on the books for 60 days or longer will be charged a fee of 66% a month for an ANNUAL PERCENTAGE RATE) OF 7.92%, on the unpaid balance. My signature acknowledges that I understand this policy: Signature: X			
hereby authorize Franco & Associates Dentistry to release to my insurance company any information, including diagnosis and records of treatment concerning my dental care. Signed: XPatient or Guardian 8. INTEREST CHARGE AND CREDIT POLICY All bills are considered due within 30 days of service. If you cannot pay the balance, please contact our credit department to arrange for an extended payment plan. Any charge carried on the books for 60 days or longer will be charged a fee of 66% a month for an ANNUAL PERCENTAGE RATE) OF 7.92%, on the unpaid balance. My signature acknowledges that I understand this policy: Signature: X	RECORDS RELEASE		
8. INTEREST CHARGE AND CREDIT POLICY All bills are considered due within 30 days of service. If you cannot pay the balance, please contact our credit department to arrange for an extended payment plan. Any charge carried on the books for 60 days or longer will be charged a fee of 66% a month for an ANNUAL PERCENTAGE RATE) OF 7.92%, on the unpaid balance. My signature acknowledges that I understand this policy: Signature: X		stry to release to my insurance company any informatio	on, including diagnosis and records
8. INTEREST CHARGE AND CREDIT POLICY All bills are considered due within 30 days of service. If you cannot pay the balance, please contact our credit department to arrange for an extended payment plan. Any charge carried on the books for 60 days or longer will be charged a fee of 66% a month for an ANNUAL PERCENTAGE RATE) OF 7.92%, on the unpaid balance. My signature acknowledges that I understand this policy: Signature: X		Signed: X	
All bills are considered due within 30 days of service. If you cannot pay the balance, please contact our credit department to arrange for an extended payment plan. Any charge carried on the books for 60 days or longer will be charged a fee of .66% a month for an ANNUAL PERCENTAGE RATE) OF 7.92%, on the unpaid balance. My signature acknowledges that I understand this policy: Signature: X		Patient or Guardian	
All bills are considered due within 30 days of service. If you cannot pay the balance, please contact our credit department to arrange for an extended payment plan. Any charge carried on the books for 60 days or longer will be charged a fee of .66% a month for an ANNUAL PERCENTAGE RATE) OF 7.92%, on the unpaid balance. My signature acknowledges that I understand this policy: Signature: X			
My signature acknowledges that I understand this policy: Signature: XDate:Date:Date:	All bills are considered due within 30 days of s an extended payment plan. Any charge carrie	service. If you cannot pay the balance, please contact of ed on the books for 60 days or longer will be charged a	our credit department to arrange for fee of 66% a month for an
Signature: X			
9. REFERRAL (If you are a new patient) Thank you for selecting our practice. It would be helpful to know why you selected us. □ Referred by friend/family □ Referred by Doctor/Dentist □ Convenient to home/work □ Saw your ad In □ Yellow Page Ad □ Other (specify)			_ Date:
Thank you for selecting our practice. It would be helpful to know why you selected us. Referred by friend/family Convenient to home/work Yellow Page Ad			
□ Referred by friend/family □ Referred by Doctor/Dentist □ Convenient to home/work □ Saw your ad In □ Yellow Page Ad □ Other (specify)	5. NEFERNAL (If you are a new patient) Thank you for selecting our	practice. It would be helpful to know why you selected	US.
Convenient to home/work □ Saw your ad In Yellow Page Ad □ Other (specify)			st
	· · · · · · · · · · · · · · · · · · ·	□ Saw your ad In	
(See other side)	Yellow Page Ad		

Dental History

1. Is this your child's first visit to a dentist? yes no			
2. If no, give date of last examination.	Dentist's Name		
3. Has your child ever had any of the following? Please check.			
abscesses (gum boils)	toothaches		
cold sores (fever blisters)	bad breath		
injury to front teeth	stained teeth		
frequent sore throats	bleeding gums		
4. Does (or did) your child have habits which might affect oral health? If y	es, check.		
clenching or grinding teeth	mouth breathing		
finger or thumb habits	other		
5. Does your child have a speech problem? ges no			
6. Does your child take fluoride at school?			
Medical History			

			Yes	No
1.	Does your child have any health problems?			
	If yes, explain.			
2.	Did your child have a history of health problems at birth or during infancy?			
	If yes, explain.			
3.	Is your child taking any medication or drugs at this time?			
	Please list		1	
4.	Has your child ever had any unfavorable reactions to foods, drugs, or medicines?			
	Please list			
5.	Has your child ever been hospitalized or injured? Date			
	Reason:			
Does your child have any limitations to sports activities?				
	If yes, explain			
7.	Has your child ever had any history of the following? HIV/AIDS		Vec 🗌	No 🗌
All	ergies Yes No Anemia			No 🗌
Dia	abetes			No 🗌
Ep	ilepsy Yes No Fainting spells			No 🗌
He	eart murmur Yes No Jaundice			No 🗌
	eumatic fever Yes No Hepatitis		Yes	No 🗌
	ngenital heart defects Yes No Asthma or hay fever			No 🗌
Seizures			Yes 🗌	No 🗌
(Comments			
8.	Name of pediatrician or family physician			
AddressPh				
9.	Does your child have problems in :			
	concentrating learning cooperating understanding			
10	. Do you think your child will be a cooperative patient?			
۱h	ereby authorize the administration of such medications and performance of such diagnostic and therapeutic p	rocedure	es as may	be
ne	cessary for proper dental care.			