Patient Registration Information

Michael A. McCoy, D.D.S
2200 South Morgan St. Granbury, Texas 76048

Name of Child: _____ Sex: ◯M ◯F
First Last Middle Initial

Date of Birth: _____ Age: _____ Nickname: _____

Email Address: _____

Mailing Address: _____
Street City, State, Zip Code

How did you hear about our office? _____
Whom may we thank for referring you? _____

Father's/Guardian's Name:	Mother's/Guardian's Name:
_____	_____
Address (If different from patients):	Address (If different from patients):
_____	_____
_____	_____
Cell Phone: _____	Cell Phone: _____
Soc. Sec. # _____	Soc. Sec. # _____
Date of Birth: _____	Date of Birth: _____
Do you have dental insurance for child: ◯ Y ◯N	Do you have dental insurance for child: ◯ Y ◯ N
Plan Name: _____	Plan Name: _____
Phone #: _____	Phone #: _____
Group #: _____	Group #: _____
Member Id #: _____	Member Id #: _____
Employer: _____	Employer: _____

Emergency Contact

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Time 9:25 AM | Michael A. McCoy, D.D.S | Date 9/2/2020

Children's Dental/Medical History 2020

Patient Name: | Birth Date: | Date Created:

Dental Habits/ History

Does child use floss daily? How Many times per week?	Yes No	If yes	
Does child brush teeth daily?	Yes No	If yes	
Is fluoride taken in any form?	Yes No	If yes	
Any injuries to mouth, teeth, or head?	Yes No	If yes	
Any unhappy dental experiences?	Yes No	If yes	
Has child complained about dental problems?	Yes No	If yes	
Any mouth habits: thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, etc.?	Yes No	If yes	

Medical History

Is child currently under care of a physician now?	Yes No	If yes	
Is child receiving any medication or drugs?	Yes No	If yes	
Has child ever been hospitalized?	Yes No	If yes	
Has child ever had a surgery?	Yes No	If yes	

Are you allergic to any of the following?

Aspirin	Yes No	Penicillin	Yes No	Codeine	Yes No	Acrylic	Yes No
Metal	Yes No	Latex	Yes No	Sulfa Drugs	Yes No	Local Anesthesia	Yes No

Other Please List | Yes No | If yes

Has child had any history of or difficult with any of the following? If yes, please check:

Aids/HIV	Yes No	Anemia	Yes No	Asthma	Yes No	Bladder Problems	Yes No
Cancer	Yes No	Cerebral Palsey	Yes No	Chicken Pox	Yes No	Diabetes	Yes No
Drug/Alcohol Abuse	Yes No	Epilepsy	Yes No	Fainting	Yes No	Hearing Problems	Yes No
Heart Murmur	Yes No	Gag Reflex	Yes No	Kidney Disease	Yes No	Liver Disease	Yes No
Hepatitis	Yes No	Measles	Yes No	Mumps	Yes No	Rhuematic Fever	Yes No
Sinus Problems	Yes No	Thyroid Disease	Yes No	Tuberculosis	Yes No	Convulsions	Yes No

Signature of Patient, Parent or Guardian:

X Date:_____

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2200 South Morgan St.
Granbury, TX 76048

FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

(Please read carefully)

WE ARE NOT CONTRACTED PROVIDERS FOR ANY INSURANCE COMPANY.

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our office policy.

Payment for ALL services is due at the time of service unless payment arrangements have been made in advance. Our office does not have a long-term payment plan. We accept cash, checks, Mastercard, Visa, and Discover. In special instances we may accept insurance assignment of benefits but we require a completed insurance form be presented at the first office visit. If the insurance claim has not been paid within 45 days it will then become your responsibility to pay the account in full.

Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 12% per annum. Charges may also be made for broken or cancelled appointments without a 24 hour notice. A $25.00 an hour fee will be charged to your account for missed appointments**. PARENTS: Co-pays for any services for dependents are due on date of service. Treatment plans are provided prior to appointments with estimated co-pays. If needed, a prior arrangement with a parent needs to be taken care of before the child's appointment. Copays need to be paid in full at or before the child's appointment.**

We will gladly discuss your proposed treatment and answer any questions relating to our policy. You must realize however that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts; every plan differs. Some insurance companies arbitrarily select certain services they will not cover. The responsibility of knowing the coverage of your policy is yours and not ours.

We must emphasize that as dental care providers, our relationship is with you, NOT your insurance company. While filing of insurance is a COURTESY that we extend to our patients, all charges are your responsibility from the date the services are rendered. We also realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the office immediately for assistance. Non-payment of your bill will force us to turn your account over to a collection agency.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

Signature_____ Date: _____

Michael A. McCoy, DDS
2200 South Morgan St. Granbury, Texas 76048

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(This entire page must be completed)

Date authorization initiated: ____/____/____

Patient's name: _____ **Date of birth: _____**

Information to be Used or Disclosed:

My dental information relating to the following treatment or condition:

□ Most recent _____ years of record

□ My dental records for the following date(s):_____

□ Entire dental record

Authorization to contact you:

Home: _____ May we leave a message YES/NO

Cell: _____ May we leave a message YES/NO

Work: _____ May we leave a message YES/NO

Purpose of Use or Disclosure:

□ Treatment, Payment or Health Care Operations

□ Disclosure of Personal Information for Insurance Coverage Purposes

□ Release of X-ray Records to different provider

To the Following Family Members: _____

Health Care Providers: _____

This Authorization will: □not expire or □expires on ___/___/___

Authorization and Signature: **To complete our office's compliance with the HIPAA policies it is necessary to have written permission to disclose patient information to your insurance company, individuals or agencies of your choice. Patient information may be disclosed without patient authorization to federal, state, and other oversight activities; public health activities and emergencies; judicial and administrative proceedings; and to a law enforcement official with a warrant or subpoena.** I authorize the release of my confidential protected dental information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected dental information.

Signature of patient: _____

Relationship to patient if Personal Representative: _____