COOL MOUNTAIN KIDS
PEDIATRIC DENTISTRY

Registration (Please Print)

CHILD'S INFORMATION

Name _____ **Nickname**_____ **Date of Birth**_____

Social Security #_____-_____-_____ **School Name/District**_____

Address _____ **City:**_____ **State:**_____ **Zip:**_____

Primary Telephone (____)_____ **Gender (circle)** Male/Female

PARENT/GUARDIAN INFORMATION

***Mother's* Name** _____ **Social Security #** _____ **Date of Birth** _____

Relationship (circle) Mother/Stepmother/Guardian **Primary Phone** _____ **Additional Phone** _____

Address (if different) _____ **Employer** _____ **Work Phone** _____

City:_____ **State:**_____ **Zip:**_____ **Email**_____

***Father's* Name** _____ **Social Security #** _____ **Date of Birth** _____

Relationship (circle) Father/Stepfather/Guardian **Primary Phone** _____ **Additional Phone** _____

Address (if different) _____ **Employer** _____ **Work Phone** _____

City:_____ **State:**_____ **Zip:**_____ **Email**_____

EMERGENCY CONTACT (other than parent/guardian)

Name:_____ **Phone:** _____ **Relationship:** _____

Who is responsible for this account?_____ **Who is accompanying the child today?**_____

How did you hear about us? _____

DENTAL INSURANCE INFORMATION

Insurance Co. Name _____ **Member Benefits Phone** _____ **Group #**_____

Claims Address _____

Policy Owner's Name _____ **Relationship to Patient** _____ **Date of Birth**_____

Policy Owner's SSN _____-____-_____ **Policy Owner's Employer** _____

- **We invite you to discuss any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between the provider and patient.**
- **If your account is not paid when due and is turned over to a collection agency for collection, the patient or responsible party will be liable for and will pay a collection fee of 20% of the unpaid bill; interest will accrue at 1.5% per month (18% APR); reasonable attorney fees of 15%; plus the unpaid principle, and any cost added by the court. Returned checks are subject to a $35.00 surcharge.**
- **I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.**
- **I understand the information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.**
- **I acknowledge I am financially responsible for all charges incurred, regardless of insurance coverage. I authorize Derek Miller, D.D.S. and his staff to administer any treatment necessary in case of medical emergency and assume all financial responsibility, and hold Derek Miller D.D.S. and employees harmless of any expense, whether incurred in the office or elsewhere, including emergency transportation cost.**
- **We do not provide amalgam fillings in our office. It is possible that your insurance may downgrade resin fillings (tooth colored fillings) to amalgam fillings and pay based on that fee. If so, you are responsible for the difference.**
- **If you need to reschedule your appointment, please call 24 business hours prior to your scheduled appointment; failure to do so is considered a broken appointment and you will be assessed a fee of $50.00. The fee must be paid prior to making other appointments.**

Signature:_____ **Date:**____/____/_____ ☐ Parent ☐ Guardian