

NEW PATIENT REGISTRATION

Confidential

Child
 Name _____ Female _____ Male _____
LAST FIRST MIDDLE

Preferred name _____ Date of birth _____ Month _____ Day _____ Year _____

Mailing address
 Street _____ Apt # _____

City _____ State _____ Zip _____

Child's School
 Daycare/Preschool/School _____ City _____

Siblings
 Name & age _____

Mother
 Name _____ Date of birth _____

Employer _____ Occupation _____

Phone. Home _____ Work _____ Ext _____ Cell _____
 Address, if different from mailing. Street _____ Apt# _____ City _____ State _____ Zip _____

Father
 Name _____ Date of birth _____

Employer _____ Occupation _____

Phone. Home _____ Work _____ Ext _____ Cell _____
 Address, if different from mailing. Street _____ Apt# _____ City _____ State _____ Zip _____

Marital status
 of child's parents _____ Married _____ Separated _____ Divorced _____ Widowed _____ Single _____

Financial responsibility
 for account. Name _____ Relation to patient _____ Social sec # _____

Child's dental insurance
 Name _____ Insurance phone # _____

Insurance subscriber name _____ Insurance member ID # _____ Insurance group # _____

Insurance billing address. Street _____

City _____ State _____ Zip _____

Referral Who may we thank for referring you? _____

Consent & Authorization By my signature below, I authorize the following: 1) Release of any and all information including the diagnosis, records of treatment or examination rendered my child during the period of dental care, to third party payers and health practitioners. 2) Use of this signature on all insurance claim submissions. 3) Payment directly to the dentist of all insurance benefits otherwise payable to me for services rendered. 4) I understand that my dental insurance carrier may pay less than the actual bill for services rendered and that I am financially responsible for all charges whether or not paid or covered by my insurance company.

Form completed by Name _____ Signature _____

Relationship to child _____ Date _____

Are you the person legally responsible for this child? Yes _____ No _____ If child is adopted, please initial here _____

Reviewed by Team member _____ Date _____

CHILD'S MEDICAL & DENTAL HISTORY

Confidential

Child's name

Child's birth date

Pediatrician/Family Doctor's Name

Doctor's phone#

ALLERGY to Medicines, Materials, Food no yes **Explain**

If any allergy, always carry emergency drugs

My child requires **special precautions** for dental treatment no yes **Explain**

Example: heart condition needing antibiotics

Does your child currently have, or ever had the following medical conditions? **Explain in space below**

Heart condition (murmur/defect/ surgery)	no	yes	Bleeding or blood clotting problem	no	yes
Diabetes	no	yes	Hepatitis or liver problem	no	yes
Asthma	no	yes	Special immunology (AIDS/HIV)	no	yes
Kidney problem	no	yes	Behavior or emotional problem	no	yes
Bone or joint problem	no	yes	Delay in normal development	no	yes
Congenital or birth defect	no	yes	Any medical condition not listed here	no	yes

Explain medical condition not listed above

List medications child is currently taking

Previous dental experience Dentist's name

Date of visit

Procedures done at previous dental visit

Reason for today's visit

Any questions about dental care?

Consent & Authorization By my signature below, I authorize dental treatment on my child and understand the following:
 1) To the best of my knowledge the above information is accurate, and will not hold Girish Banaji, DDS, PC or his team members responsible for any errors or omissions made while completing this form. 2) Providing incorrect information is dangerous to my child's health and safety, and it is my responsibility to inform Dr. Banaji or his team members when there is a change in my child's medical condition, or when there is a change in the responses to any of the above questions.

Form completed by Name

Signature

Relationship to child

Date

Are you the person legally responsible for this child?

Yes

No

If child is adopted,
please initial here

Reviewed by team member

Date

Patients with insurance coverage As a courtesy, a claim is filed with your dental insurance company using information you provide us. Therefore, you must provide accurate information; a fee is charged for resubmitting a claim when incorrect information is provided. Insurance has limitations, restrictions and partial coverage for most dental services; example: fluoride treatment, sealant, resin/white filling, crown. Without exceptions, payment is required at the time of service for patient portion – deductible, co-pay amounts. Please note that we can only estimate the patient portion – it is not the exact amount you owe. The exact patient portion will be known only after the claim is processed by your insurance, and a statement is then mailed to you for any balance amount.

Patients without insurance coverage Treatment plan with estimate of fees is provided prior to starting dental treatment. Without exceptions, full payment is required at the time of service.

Minor patients Both parents or guardians are financially responsible for full payment at the time of visit. In the case of divorced or separated parents, both parents are responsible for full payment, without any exceptions.

Payment methods Cash, check, debit, and credit cards: MasterCard and Visa.

Returned checks \$40.00 charge applies when a check is returned by the bank due to insufficient funds.

Finance charge After a dental claim is processed by insurance, a statement is mailed to the address on record for the remaining balance. Payment is expected within 25 days of the statement date, to avoid 1.5% monthly finance charge.

Refunds An account with credit balance is issued a refund check in the name of the person shown under “Financial Responsibility for account” and mailed to the address on file. You may choose to keep the credit balance in our office for use towards future dental care.

Missed Appointment Fee – 24 hour notice needed To reschedule an appointment, our office must be notified at least twenty four (24) hours in advance to avoid a missed appointment fee of \$50.

Termination of Treatment Our office reserves the right to cancel future appointments and terminate professional relationship for any of these reasons: 1) when scheduled appointments are not kept, 2) when patient arrives late to scheduled appointments causing inconvenience to other patients 3) Uncollected debt owed (past due account) to this office.

Member American Credit Bureau Inc Our accounting department promptly reports past due and delinquent accounts to the national credit bureaus – Equifax, Experian, and Trans Union.

Financial Responsibility Agreement By signing this document, I understand and agree to the following:

- 1) I am responsible for payment of all charges for services rendered, regardless of insurance coverage.
- 2) Unpaid balance for more than 30 days after services are rendered is subject to interest of 18% per annum.
- 3) Unpaid balance over 60 days is reported to American Credit Bureau Inc. The debt owed to this office will appear on my permanent credit file at the nation’s leading credit bureaus – Equifax, Experian and Trans Union. To collect the debt, such an account may also be sent to an attorney or collections agency and I agree to pay 33.3% attorney’s fees, all court costs and fees associated with the collection efforts.

Consent & Authorization I have read and understood this document in its entirety outlining office policies, patient and family responsibilities, and without reservations agree to abide by all the items stated herein. I authorize dental treatment on my child after it has been explained to me by the dentist or team member.

Form completed by Name Signature

Relationship to child Date

Are you the person legally responsible for this child? Yes No

Reviewed by team member Date

**Acknowledgement
Statement of
Privacy Practices**

Please print and sign this page

Girish Banaji, DDS, PC
8505 Arlington Blvd. Ste. 370
Fairfax, Virginia 22031
703. 849.1300
www.banajidds.com

I acknowledge that I have received the Statement of Privacy Practices (“Statement”) for the office of Girish Banaji, DDS, PC. The Statement describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. Also, it describes my rights and the responsibilities and duties of the office with respect to my protected health information. The Statement is posted in the facility.

Girish Banaji, DDC, PC reserves the right to change the privacy practices that are described in the Statement. If privacy practices change, I will be offered a copy of the revised Statement at the time of my first visit after the revisions become effective.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described on the reverse of this page, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family		YES		NO
Spouse only		YES		NO
Other (please specify):		YES		NO

Name of Patient

Signature of Patient or Personal Representative

Date

Relationship to Patient

OFFICE USE ONLY, BELOW THIS LINE

Record of Acknowledgement not obtained			
Provided prior to treatment?	yes	no	
Date provided			
Reason for denial		Needed more time to review statement of privacy practice	
		Wanted to consult with another person, before signing	
		Unable to sign	
		Reason not given	
		Other (Explain)	