13410 New Halls Ferry Rd, Florissant, MO 63033
Phone: 314.830.9663
Fax: 314.830.9664
www.thechildrensdentalzone.com
www.trilogydentalgroup.com

PATIENT REGISTRATION

Dr. Candace T. Wakefield

CHILD'S LAST NAME:_____ FIRST NAME:_____ MI:_____
NICKNAME:_____ BIRTH DATE:_____ ☐ MALE ☐ FEMALE
MOTHER'S NAME:_____ HOME TELEPHONE:_____
ADDRESS:_____ CITY/STATE/ZIP:_____
E-MAIL ADDRESS:_____ CELL PHONE:_____
MOTHER'S SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____
EMPLOYED BY:_____ TELEPHONE:_____
FATHER'S NAME:_____ HOME TELEPHONE:_____
ADDRESS:_____ CITY/STATE/ZIP:_____
E-MAIL ADDRESS:_____ CELL PHONE:_____
FATHER'S SOCIAL SECURITY NUMBER:_____ DATE OF BIRTH:_____
EMPLOYED BY:_____ TELEPHONE:_____
DENTAL INSURANCE NAME:_____ TELEPHONE:_____
MAILING ADDRESS FOR CLAIMS:_____ CITY/STATE/ZIP:_____

FINANCIAL AGREEMENT

I am responsible for any financial obligations incurred in connection with dental treatment rendered on behalf of my child. I understand that payment must be paid at the time services are rendered and that I am responsible for any charges incurred which are not covered by dental insurance. I further understand there will be a $25.00 late fee for any outstanding balances over 31 days.

Please provide 24 hours prior notice to cancel or reschedule an appointment. We charge a $58.00 broken appointment fee for any missed appointments in the event adequate notice is not provided.

PARENT/GUARDIAN SIGNATURE:_____

PERMISSION FOR TREATMENT UPON A MINOR

I, being the parent or legal guardian of the above minor patient, hereby authorize and request the performances of dental services for this patient; and further, the performance of whatever procedures the judgment of the named doctor may consider necessary during the performance of any operation. In addition I also authorize the administration of whatever anesthetics or analgesics which the doctor deems advisable during the rendering of care.

PARENT/GUARDIAN SIGNATURE:_____
DENTIST SIGNATURE:_____ DATE:_____

HIPAA ACKNOWLEDGMENT

I acknowledge that I have received a copy of The Children's Dental Zone *Notice of Private Practices* and understand I have a right to review prior to signing this document.

PARENT/GUARDIAN SIGNATURE:_____
PRINT NAME:_____ DATE:_____