WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask, we will be happy to help.

Patient Name_____D.O.B._____

Responsible Party

Who is the responsible party?_____Relationship_____

Birthday_____Driver's License_____

Social Security_____

Address(include city, state, zip) _____Apt_____

Employer_____Occupation_____

Work Phone #_____EXT____ Home phone #_____Cell_____

Dental Insurance Information

Primary Insurance Coverage

Name of Insured_____Relationship to patient_____

Insured's Birthday_____Social Security_____Employer_____

Name of Insurance Company_____Group #_____

Additional Insurance

Name of Insured_____Relationship to patient_____

Insured's Birthday_____Social Security_____Employer_____

Name of Insurance Company_____Group #_____

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____ _____

Signature of patient or parent/guardian Date

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer. Payment is required in full at each appointment.

___Cash ___Personal Check ___Credit card (Visa, Master card, Discover, American Express)

Late Charges

If I do not pay the entire balance within 25 days of the monthly billing date, a late charge of $35.00 will be added to my account. I realize that failure to keep my account current may result in you being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask, we are always happy to help!

Pediatric Dentistry of Mobile, P.C.
Marion B. McMurphy, Jr., D.M.D.
Joel B. Welford, D.M.D.

THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US TO A BETTER UNDERSTANDING OF YOUR CHILD

Child's Name: _____ Nick Name (if any):_____
Age: _____ Birthdate _____ Place of Birth _____
Attends what school _____
Name and age of brothers _____
Name and age of sisters _____
Child's Physician / Pediatrician _____
Family Dentist _____
**Whom may we thank for sending you to us? _____
Their Address _____
Purpose of call _____
Name of child's pet and child's hobby _____

	YES	NO
1. Is your child in poor health?	____	____
2. Has your child had any history of epilepsy, blood disorders, cerebral palsey, heart troubles, allergies, diabetes, asthma, kidney or liver disorder (If yes, underline condition) for which he/she has received treatment medicine?	____	____
3. Has you child had any unfavorable reaction to drugs, or allergies to medicine?	____	____
4. Has your child had any history of thumb sucking, finger sucking, lip biting or nail biting? (If yes, please underline which)	____	____
5. Is your child adopted?	____	____
6. Has mother or father had a lot of decay?	____	____
7. Has your child had any unfavorable experience in a dental or medical office?	____	____
8. Is your child taking any medications? if yes, What?	____	____
9. Do you consider your child to be high strung or generally nervous?	____	____
10. Has your child had a tooth ache recently?	____	____

11. Give dates of last dental care: _____ Where? _____
12. Remarks: (Use reverse side if needed) _____

Father: _____
Mother: _____
Home Address _____ Phone: _____
City _____ State _____ Zip _____
Email Address _____
Father's Employer _____ Phone: _____
Business Address _____ Father's Cell: _____
Mother's Employer _____ Phone: _____
Business Address _____ Mother's Cell: _____
Name of closest relative: _____ Phone: _____
* If you have previously completed this form for another child, please give that child's name:_____

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and / or all necessary dental service can be started and accomplished by Dr. McMurphy or Dr. Welford. Authorization is hereby granted as such. Furthermore, I will be responsible for any bill incurred on the child for dental treatment and for any legal costs, including a reasonable attorney fee, if account is turned over for collection.

Signed: _____
Parent or Guardian
Date: _____

Marion B. McMurphy, Jr., D.M.D., PA
Joel B. Welford, D.M.D.
Pediatric Dentistry of Mobile, P.C.

Office Policy Statement
Revised April 28, 2010

Dr McMurphy and Dr. Welford would like to welcome you to their practice. Our office staff will do everything possible to make your visits go smoothly. Please read this form carefully and be sure to sign the bottom.* We are looking forward to seeing you.

Insurance and Billing:
Please realize that your insurance is a contract between you and your insurance company. You are financially responsible for any services or deductibles not covered by your insurance plan.

All co-payments and deductibles are due at the time of service. We will do our best to estimate your percentage at that time. We accept cash, checks, Visa, Master card, American Express, and Discover. ***Whoever brings your child in for any treatment will be responsible for payment that day unless prior arrangements are made with one of our staff. We use Nitrous Oxide on children for treatment, which there is a charge. Most insurance companies do NOT cover this charge, so this will be due at the time of service.

There will be a $35.00 charge for all returned checks. Financial arrangements for treatment must be made in advance.

Thank you!!!

I have read and agree to this office policy statement and I am aware that this policy statement is subject to change without notice.

*_____ _____
Signature Date