

Email: \_\_\_\_\_  
\_\_\_\_\_

Michael P. Berry, D.D.S., P.C.

Pediatric Dentistry

(Sign here for permission to communicate via email) 6004 N.W. 9 Hwy. ♦ Parkville, MO 6415

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ School/Grade \_\_\_\_\_

(CIRCLE ONE)

Father / Step / Guardian / Foster

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Father's Date of Birth (this must be listed) \_\_\_\_\_

Father's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell # \_\_\_\_\_ Pager # \_\_\_\_\_

(CIRCLE ONE)

Mother / Step / Guardian / Foster

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Mother's Date of Birth (this must be listed) \_\_\_\_\_

Mother's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell # \_\_\_\_\_ Pager # \_\_\_\_\_

Who is responsible for this account? \_\_\_\_\_

Child's Physician \_\_\_\_\_ City \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Child's previous dentist \_\_\_\_\_ Last Exam Date \_\_\_\_\_

### HEALTH HISTORY

Is your child now under a physician's care?	YES	NO	Does your child take vitamins?	YES	NO
Has your child ever been hospitalized?	YES	NO	Do you have dental insurance?	YES	NO
Is your child HIV positive or have "AIDS"?	YES	NO	Does your child have a developmental		
Does your child take any medications?	YES	NO	disability?	YES	NO
If yes, please specify _____					

**Has your child had any of the following:** (Circle One)

Allergies to food or drugs? _____	YES	NO
If yes, please specify _____		
Asthma or hay fever? _____	YES	NO
Blood disorders or transfusions?	YES	NO
Diabetes?	YES	NO
Epilepsy or seizure disorder?	YES	NO
Heart trouble or heart murmur?	YES	NO
Kidney or liver disorder?	YES	NO
Respiratory infection or disorder?	YES	NO
Rheumatic or scarlet fever?	YES	NO
Headaches or TMJ Problems	YES	NO

PERMISSION FOR TREATMENT UPON A MINOR CHILD

I, being the parent or guardian of the minor child named on the reverse, do hereby authorize and request the performance of dental services for this patient; and further, the performance of whatever additional procedures may be necessary for the preservation of the health of this child, as deemed necessary by the above named doctor during the performance of any operation. I understand that I will be informed of all procedures and their charges before any work is begun.

I also authorize the administration of analgesics and/or local anesthetics which may be deemed advisable by the doctor.

Further, I will be responsible for any financial obligations incurred for dental treatment for this child. I understand that payment must be made at the time the services are rendered, unless other specific arrangements have been made.

I authorize the dentist and/or dental staff to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist 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.

I understand that any lack of notification of a missed appointment or an appointment which is 15 or more minutes late is considered a broken appointment. After two broken appointments, the doctor/patient relationship may be terminated.

I further understand that should my account become delinquent and collection services are required, I am responsible for all collection and legal fees incurred.

Please note that there is a 2% financial charge on all outstanding balances on your account.

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relationship to Patient

Emergency Contact Information

Who may we contact in the event of an emergency? (Other than family members.)

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Cell Phone/Pager (\_\_\_\_\_) \_\_\_\_\_

Please Note:

Should your insurance coverage change you must inform us within two weeks of any scheduled procedure (whether in office or hospital). Otherwise, all costs will be collected based on the insurance information obtained at the initial appointment and you will be responsible for filing and receiving reimbursement from new insurance. Should your insurance coverage change to less coverage we still request that you notify us within two weeks and you will be responsible for the difference in cost.

**OUR OFFICE DOES NOT OFFER FINANCING HOWEVER WE ARE PLEASED TO ACCEPT PERSONAL CHECKS. DISCOVER. VISA MASTER CARD AND AMERICAN EXPRESS**