13841 Hull Street Road, Suite 4
Midlothian, VA 23112
804.739.0963 | 804.745.0100

Pediatric Dentistry and
Orthodontics of Virginia
www.pdova.com

651 Southpark Boulevard
Colonial Heights, VA 23834
804.526.9815

Patient Registration

1. Patient's Name ______________________________
   D.O.B. ______________ Age __________ Sex (M or F) __________

2. Patient's Name ______________________________
   D.O.B. ______________ Age __________ Sex (M or F) __________

3. Patient's Name ______________________________
   D.O.B. ______________ Age __________ Sex (M or F) __________

Father's Name ______________ Marital Status ______________
SS # ______________ D.O.B. __________ Home # __________
Street Address ______________ C/S/Zip ______________
Employer/Business Name ______________ Business # __________
Cell ______________ email ______________

Mother's Name ______________ Marital Status ______________
SS # ______________ D.O.B. __________ Home # __________
Street Address ______________ C/S/Zip ______________
Employer/Business Name ______________ Business # __________
Cell ______________ email ______________

With whom do children live? ______________________________
How did you find out about our office? ______________________________

Name of Insurance Company ______________________________
Address ______________________________
Phone # ______________________________
Subscriber's Name ______________________________
Identification # ______________ Group # ______________

Secondary Insurance Company ______________________________
Address ______________________________
Phone # ______________________________
Subscriber's Name ______________________________
Identification # ______________ Group # ______________

Financial Responsibility Statement

Please read the following information carefully and completely, then sign and return to the receptionist.

In consideration of dental services to be rendered to my child at my request, I understand that I owe and agree to pay Pediatric Dentistry and Orthodontics of Virginia. I also understand that if any check or charge rendered by me for payment of services is returned for any reason, a fee will be billed to my account. Also, if there is an outstanding balance on my account for over 60 days, a finance charge of 1.5% will be applied. I agree to be responsible for any collection fees.

Dental Insurance:

I understand that if my insurance cannot be verified at the time of the scheduled appointment, I will be charged the usual and customary office fees for services rendered at the time of the visit. I recognize that PDOVA will bill and attempt to collect from my insurance company as a courtesy; however, my insurance is my responsibility. I fully understand PDOVA may not accept my insurance company's usual and customary fee (UCR) as payment in full. This may lead to a bill (balance) for deductible, co-payments for procedures not covered at 100% and a difference in fee for service and the UCR allowed by my insurance. My co-payment is estimated and due at the time of service, however, any change or balance remaining due to a change from my insurance, I agree to pay. I understand that it is my responsibility to furnish this office with a copy of my insurance card or a claim form with all information needed to file. It is my responsibility to update the office with any changes in my insurance.

I am responsible for understanding my individual insurance policy and benefits prior to seeking services. If my insurance has not made a payment after 45 days of billing. the balance is my responsibility. If the information I have provided is not correct, I will be responsible for payment of claims denied as a result of the incorrect information.

I authorize and release information and payment of my dental insurance to the dentists of PDOVA.

I have read and understand fully the above statements or I have asked questions and received the satisfactory answers. I understand the content of this form and agree to the terms contained herein. I certify that all information supplied by me as part of the patient registration is correct.

Purpose of this visit ______________________________

Is this the child's first visit to the Dentist? ______________________________

If not, name the previous D.D.S. ______________________________

Date of last visit ______________________________

What was done? ______________________________

Does previous D.D.S. have current x-rays? ______________________________

Date and type of x-rays? ______________________________

Will D.D.S. send x-rays? ______________________________

Are there any medical problems? ______________________________

Appointment date and time ______________________________

Parent/Guardian Signature:
(Must Be Legal Guardian) ______________________________ Date: ____________

Print Name: ______________________________

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