Pediatric Patient Registration

Thank you for choosing our office to assist you with your dental needs.

Please fill out the information below then include your signature and date.

Patient's Name _____ Nickname _____

Male ☐ Female ☐ Birthdate _____ Age _____ Hobbies _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Whom may we thank for referring you? _____

Notify in case of Emergency: _____ Relationship to patient: _____

Father's Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer _____ Soc. Sec. # _____

Mother's Name: _____ Birthdate: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer _____ Soc. Sec. # _____

Primary Insurance Subscriber : _____ Relationship: _____

Is the subscriber a patient here? Yes ☐ No ☐

Insured Employed by: _____ Occupation: _____

Insurance Company: _____ Phone: _____

Subscriber Number: _____ Group Number: _____

Name(s) of other dependents on this plan: _____

Dental History

Former Dentist: _____ Phone: _____

Date of last visit: _____ Date of last x-rays: _____

Has child complained about dental problems? Yes ☐ No ☐ (If Yes, please explain) _____

Does child brush teeth daily? Yes ☐ No ☐

Does child floss daily? Yes ☐ No ☐

Is fluoride taken in any form? Yes ☐ No ☐

Any injuries to mouth, teeth or head? Yes ☐ No ☐

Any unhappy dental experiences? Yes ☐ No ☐ (If Yes, please explain) _____

Any mouth habits - thumb sucking, nail biting, mouth breathing, pacifer, sleeping with bottle, etc...? Yes ☐ No ☐ (If Yes, please explain)

_____

PEDIATRIC MEDICAL HISTORY

Patient's Name: (Print)_____ **Date of Birth:** _____

Has minor child had any history of or difficulty with any of the following? (If YES, Please Check)

- ☐ ADD / ADHD
- ☐ Anemia / Blood Disorders
- ☐ Anxiety
- ☐ Artifical Heart Valve
- ☐ Asthma
- ☐ Autoimmune Disease
- ☐ Bladder Problems
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Convulsions
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Epilepsy / Seizures / Fainting
- ☐ Hearing Problems
- ☐ Heart Defect
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraines / Frequent Headaches
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic / Scarlet Fever
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Stent
- ☐ Thyroid Disease
- ☐ Tumor

Does your child have any disease, condition or problem not listed above? *(If YES, please explain)*

_____

Is your child allergic to, or has reacted adversely to any of the following? *(If YES, please check)*

- ☐ Aspirin
- ☐ Barbiturates, Sedatives, Sleeping Pills
- ☐ Codeine or Other Narcotics
- ☐ Latex Materials
- ☐ Local Anesthetics (Novocaine)
- ☐ Penicillin or Other Antibiotics
- ☐ Sulfa Drugs
- ☐ Other: _____

Primary Care Physician:

_____

Recent Surgeries:

_____

List ALL Current Medications:

_____

Have there been any changes to the following? Address / Phone Number / Pharmacy / Insurance

_____

_____

_____

Parent Signature: _____ **Date:** _____

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices. I understand this notice contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

_____ _____

Patient Signature Date

_____ _____

Print Patient Name Birthdate

I wish to be contacted in the following manner (check all that apply):

Home Telephone _____

☐ Okay to leave message with detailed information

☐ Leave message with call-back number only

Work Telephone _____

☐ Okay to leave message with detailed information

☐ Leave message with call-back number only

Written Communication

☐ Okay to mail to my home address

☐ Okay to mail to my work/office address

☐ Okay to fax to this number

☐ Other _____

_____

CONSENT FOR TREATMENT

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

Signature: _____ Date: _____

INSURANCE AUTHORIZATION

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits, otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment, unless prior arrangements have been approved.

Signature: _____ Date: _____