By The Sea Dentistry

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Child Registration Form

Date: _____

Patient Name_____Male____Female___Age___Date of Birth_____

Nickname_____Street Address_____

Po Box _____ City_____State_____Zip_____

Home Phone_____Cell Phone_____E-Mail_____

Father's Name_____Date of Birth_____SS#_____

Cell Phone_____Employer_____

Emergency Contact Name and phone #:_____

Dental Insurance Name_____Group_____ID#_____

Address_____Phone#_____

Mother's Name _____Date of Birth_____SS#_____

Cell Phone_____ Employer_____

Dental Insurance Name_____Group_____ID#_____

Address_____Phone #_____

Whom may we thank for referring you? _____

Release:

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I authorize release of any information concerning my (or my child's) health care, advice, and treatment to another dentist.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of service not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on this page.

Patient's or guardian's signature _____

Date_____

Child Dental/Medical History Form

Patient's Name _____. Date of Birth _____ Parent's Guardian's name_____

DENTAL HISTORY (circle appropriate answer)

1. Is this your child's first visit to a dentist? YES NO
2. If not, how long since the last visit to the dentist? YES NO
3. Were any x-rays or radiographs taken when your child previously visited the dentist? YES NO
4. Does your child eat between meals? YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
6. When does your child brush his/her teeth?
   ☐ Upon arising ☐ After eating any food ☐ Right after meals ☐ Before going to bed
7. How does your child receive Fluoride? ☐ Community water level_____ppm ☐ Well water level _____ppm
   ☐ Fluoride drops or tablets ☐ Fluoride rinse or gel
8. Have any cavities been noted in the past? YES NO
9. Were any teeth (baby or permanent) removed by extraction? YES NO
   Was it suggested that the space be maintained YES NO
   Was an appliance placed YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES NO
    If so describe_____
11. Has your child had any problem with dental treatment in the past? YES NO
12. Has anyone in the family, including parents, had orthodontics? YES NO
13. Has your child ever received a local anesthetic? YES NO
14. Has your child ever had occlusal sealants? YES NO
15. Does your child think there is anything wrong with his/her teeth? YES NO

MEDICAL HISTORY (circle appropriate answer)

1. Does your child have a health problem? YES NO
2. Is your child under care of physician? YES NO
   If yes, since when and why? _____
3. Name of physician _____Phone_____
4. Is your child receiving any medication? YES NO
   What? _____
5. Is your child allergic to penicillin, antibiotics, or other drugs? YES NO
6. Is your child allergic to or sensitive to any metals or latex? YES NO
7. Does your child have other allergies? YES NO
8. Has your child had any serious illness? YES NO
   When_____What_____
9. Has your child ever had surgery? YES NO
10. Does your child have a heart murmur? YES NO
11. Is surgery contemplated? YES NO
12. Does your child experience severe or prolongated bleeding? YES NO
13. Does your child have AIDS or has he/she tested HIV positive? YES NO
14. Has your child tested positive for hepatitis? YES NO
15. Is your child subject to nervous disorders? YES NO
    ☐ Fainting ☐ Seizures ☐ Dizziness ☐ Behavioral/Learning problems
16. Does your child have frequent headaches? YES NO
17. Has your child had history of: *(circle appropriate responses)* diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.
*PATIENT'S/GUARDIAN'S SIGNATURE*_____*DATE*_____

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Patient's Financial Responsibility Statement

We reserve the right to charge a $50.00 fee for any appointments cancelled without a 48-hour notice and a $75.00 fee for any "NO SHOW" appointments since our office is scheduled by appointment only.

All dental care insurance carriers or payers of dental benefits may pay less than the actual bill for services. Therefore, you are financially responsible for payments in full of all accounts. By signing this financial agreement responsibility statement, you revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid in whole or in part by the dental care payer.

All costs necessary to collect any balance which remains unpaid for more than 30 days, including attorney's fees, which shall be calculated at one-third (1/3) of the original amount due and which shall accrue upon commencement, shall be your responsibility.

I have read and understand and agree to the above information.

Patient or Guardian's Signature _____

Date _____

Certification of Military Status

I, _____ hereby certify under penalty of perjury, that I AM_____AM NOT _____ (check one) in the active military service (including the Army, Navy, Air Force, Marines, Coast Guard and/or National Guard) of the United States of America. I further certify that, if the above status should change, I shall immediately notify your office in writing of the change.

Patient or Guardian's Signature _____

Date _____