Children's Oral Care Only PC

5530 W. Montrose
Chicago, Illinois 60641
(773) 282-8800

185 N. Milwaukee Ave.
Lincolnshire, IL 60069
(847) 478-8100

CHILD'S REGISTRATION AND HISTORY

PATIENT INFORMATION

DATE: ____________

NAME: ____________ LAST ____________ FIRST ____________ M ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE

ADDRESS: ____________ STREET ____________ APT. # ____________ CITY ____________ STATE ____________ ZIP

BIRTHDATE: ____ MO ____ DAY ____ YR. TELEPHONE: ☐ ____________ HOME ☐ ____________ OFFICE

PLACE OF EMPLOYMENT (OR SCHOOL): ____________ GRADE ________ S.S. # ____________

DENTAL INSURANCE CO.: ____________ GROUP NO. ____________

Has any member of your family ever been treated in our office? ☐ YES ☐ NO

Whom may we thank for referring you to our office? ____________

WHAT IS CHILD'S FAVORITE SPORT ____________ FAVORITE TOY ____________

FAVORITE HOBBY ____________ FAVORITE PERSON ____________ FAVORITE FICTION CHARACTER ____________

E-MAIL ____________

FAMILY INFORMATION

	GUARANTOR	SPOUSE
Name:	LAST FIRST M	LAST FIRST M
Address:	STREET CITY STATE ZIP	STREET CITY STATE ZIP
Telephone #:	HOME # WORK #	HOME # WORK #
Birthdate/SS #:	MO DAY YR SS #	MO DAY YR SS #
Employer:	EMPLOYER	EMPLOYER
Dental Insurance Co.: Group #:	DENTAL INSURANCE GROUP #	DENTAL INSURANCE GROUP #

PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE:
☐ Patient ☐ Father (or Husband) ☐ Mother (or Wife) ☐ Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

NAME ____________ LAST ____________ FIRST ____________ M TEL # ____________

ADDRESSS ____________ STREET ____________ CITY ____________ STATE ____________ ZIP

DENTAL HISTORY

	YES	NO
Date of last visit to a dentist ______		
For what service ______		
Has child complained about dental problems ______	☐	☐
Any unhappy dental experiences ______	☐	☐
Any injuries to mouth - teeth - head ______	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. ______	☐	☐
Any unusual speech habits ______	☐	☐
Any lost teeth ______	☐	☐

	YES	NO
Does your child brush teeth daily ______	☐	☐
Do you assist child with tooth brushing ______	☐	☐
How often ______		
Is dental floss used ______	☐	☐
How often ______		
Are disclosing tablets used ______	☐	☐
Is fluoride taken in any form ______	☐	☐
Child's attitude to dentistry ______		
Do you desire complete dental service for the child ______	☐	☐
Have missing teeth been replaced ______	☐	☐
Orthodontic appliances worn now or ever been ______	☐	☐

HEALTH HISTORY

Child's Physician ______ Address ______ Phone ______

Date of last physical examination ______ Results ______

	YES	NO
Is child under care of physician now ______	☐	☐
Is child receiving any medication or drugs ______	☐	☐
Is there any excessive bleeding when cut ______	☐	☐
Has child ever been hospitalized ______	☐	☐
Has child ever had surgery ______	☐	☐

	YES	NO
Does child have good physical coordination ______	☐	☐
Are there any emotional problems ______	☐	☐
Is there any allergy to penicillin or other drugs ______	☐	☐
Are there other allergies: food - pollen - animals - dust - other	☐	☐

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

___ Anemia	___ Chronic Sinus	___ Hearing	___ Mastoid	___ Thyroid
___ Asthma	___ Convulsions	___ Heart	___ Measles	___ Tuberculosis
___ Bladder	___ Diabetes	___ Kidney	___ Mononucleosis	___ Other
___ Cerebral Palsy	___ Epilepsy	___ Liver	___ Mumps	___ Venereal Disease
___ Chicken Pox	___ Fainting	___ Malignancies	___ Rheumatic Fever	

______
Patient Signature *(Parent if minor)*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

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

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care 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.*

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 operation. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Patient Name (print) ______________________________

Relationship to Patient ______________________________

Signature ______________________________ Date ______________

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name ______________________________ Date of Birth ______________

Address ______________________________

If the address provided above is not your home address or it is not a stress address, please provide us with a street for purposes of ensuring payment. *written communications

Home # ______________________ may we leave a message? Yes ______ No ______

Work # ______________________ may we leave a message? Yes ______ No ______

Cell # ______________________ may we leave a message? Yes ______ No ______

Email ______________________ may we send an email? Yes ______ No ______

May we send an appointment reminder text message? Yes ______ No ______

May we leave a message that you need pre-medication? Yes ______ No ______

May we leave a message that you have a dental appointment? Yes ______ No ______

I do not want a reminder left at all __________ (initials)

I do not want a postcard sent __________ (initials)

I understand that the office may charge me should I fail to keep my appointment * oral communications

FOR OFFICE USE ONLY

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

Date ______________________ Reason ______________________ Initials ________

Consent and Agreement to Pay

I understand that all responsibility for payment for dental and/or orthodontic services, treatments, procedures and/or diagnostic methods performed and utilized in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1 ½ % finance charge (18% APR) may be added to my account, in addition to any collection charges.

As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Guardian/Responsible Party if minor________________________Relationship to patient____________
Signature

Print Name___________________________________Date______________

Print Patient Name____________________________Date______________

Print Patient Name____________________________Date______________

Print Patient Name____________________________Date______________

Print Patient Name____________________________Date______________

Print Patient Name____________________________Date______________