kid grins
PEDIATRIC DENTISTRY

PATIENT REGISTRATION FORM

TODAY'S DATE _____

PATIENT INFORMATION:

FIRST NAME_____ **MIDDLE NAME**_____ **LAST NAME**_____

NICKNAME _____ **GENDER** _____ **DATE OF BIRTH** _____

HOME ADDRESS _____ **CITY** _____**STATE**_____ **ZIP CODE**_____

RACE (please circle) American Indian Asian Black or African American Hispanic or Latino More than one Race Native Hawaiian or Other Pacific Islander Other Race White Prefer Not to Answer

RESPONSIBLE PARTY/GUARANTOR FIRST NAME _____ **LAST NAME**_____

PARENT INFORMATION:

PARENT 1 FIRST NAME _____ **MIDDLE NAME**_____ **LAST NAME**_____

RELATIONSHIP TO PATIENT _____ **GENDER** _____ **DATE OF BIRTH** _____

HOME ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

EMPLOYER _____ **OCCUPATION** _____ **EMAIL** _____

MARITAL STATUS (please circle) Single Married Widowed Divorced Separated Other_____

PARENT 2 FIRST NAME _____ **MIDDLE NAME**_____ **LAST NAME**_____

RELATIONSHIP TO PATIENT _____ **GENDER** _____ **DATE OF BIRTH** _____

HOME ADDRESS _____ **CITY** _____ **STATE** _____ **ZIP CODE** _____

HOME PHONE _____ **CELL PHONE** _____ **WORK PHONE** _____

EMPLOYER _____ **OCCUPATION** _____ **EMAIL** _____

MARITAL STATUS (please circle) Single Married Widowed Divorced Separated Other_____

DENTAL INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY _____**GROUP #** _____ **ID #** _____

INSURANCE COMPANY ADDRESS _____

FULL NAME OF POLICY HOLDER _____ **RELATIONSHIP TO PATIENT** _____

POLICY HOLDER DATE OF BIRTH _____ **INSURED'S SOCIAL SECURITY #** _____

SECONDARY INSURANCE COMPANY _____**GROUP #** _____ **ID #** _____

INSURANCE COMPANY ADDRESS _____

FULL NAME OF POLICY HOLDER _____ **RELATIONSHIP TO PATIENT** _____

POLICY HOLDER DATE OF BIRTH _____ **INSURED'S SOCIAL SECURITY #** _____

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Your child's overall health, as well as any medications that your child takes, could have an important relationship with the dental care your child needs and is able to receive safely. Please answer each of the following questions completely.

PATIENT NAME: _____ **DATE OF BIRTH:** _____

HEALTH HISTORY:

Asthma	yes or no	Rheumatic Fever	yes or no
Allergies	yes or no	Congenital Heart Defect	yes or no
Cancer	yes or no	Handicaps/Disabilities	yes or no
Hepatitis	yes or no	Seizures/Epilepsy	yes or no
HIV/AIDS	yes or no	Tuberculosis	yes or no
Hemophilia	yes or no	Abnormal Bleeding	yes or no
Diabetes	yes or no	Heart Murmur	yes or no

Please explain **any medical issues** that your child has and **list any medications** they are taking:

_____

_____

DENTAL HISTORY:

Has your child had difficulty with previous dental visits? _____

How often does your child brush? _____ floss? _____

Previous Dentist and last appointment date: _____

Child's Physician: _____ Physician's Phone #: _____

Is your water fluoridated? _____ Does or has your child taken fluoride supplements? _____

Circle all the apply to your child: suck thumb/finger suck/bite lips bite/chew hard objects

grind teeth clench jaws other Please explain other: _____

AUTHORIZATION AND RELEASE: **To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist 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 part payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group 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.**

Signature of patient or parent/guardian if minor_____ **Date** _____

DENTIST REVIEW

Notes_____ Dr. Signature _____Date_____

Notes_____ Dr. Signature _____Date_____

Notes_____ Dr. Signature _____Date_____

Notes_____ Dr. Signature _____Date_____

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I, (printed name of parent/legal guardian) _____ give permission for the following person/people to bring my child/children to Kid Grins Pediatric Dentistry to be treated by Dr. Loeb. Until further notice, the following people are able to make decisions regarding any dental and/or medical treatment necessary while under the care of Dr. Loeb. This permission includes, but is NOT limited to cleanings, fluoride, x-rays, fillings, crowns, extractions, laughing gas (nitrous oxide), conscious sedations, space maintainers, sealants, emergency treatment, impressions, local anesthesia (Novocain), nerve treatment for a tooth, and referrals to another dentist or doctor.

People who can make decisions:

Parents: _____

Grandparents: _____

Nanny: _____

Other: _____

Child this consent applies to:

Child's Name: _____

Signature of parent/legal guardian: _____

Date: _____

Relationship to patient/patients: _____

***** PLEASE NOTE: AN ADULT MUST BE PRESENT FOR THE ENTIRE APPOINTMENT. THIS ADULT MUST BE AN ADULT THAT IS ABLE TO CONSENT TO TREATMENT FOR THE CHILD/PATIENT. *****

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Please read and sign our Office Policy Agreement:

- Please be advised that our office submits your claims to your dental insurance as a courtesy to you. This does not mean that we know what your insurance coverage is or will be. Please remember it is your responsibility to know your insurance coverage.

- You are responsible for any outstanding balance that your insurance does not cover, due in full within 45 days from the date of service. Payment plan and financing (CareCredit) options are available if needed. It is your responsibility to contact our office to set this up.

- You will be required to pay an estimate of the patient portion due for each date of service, on each date of service.

- It is your responsibility to provide us with any change to insurance, address, or phone number.

- A $30.00 fee will be charged for any non-sufficient funds checks we receive.

- We accept checks, cash, all major credit cards, Health Savings Account cards, and debit cards.

- Your appointment time is reserved exclusively for you. We require at least 24-hour advance notice to cancel or reschedule your appointment. Less than 24-hour notice may be subject to a charge of $30.00 per half hour scheduled._

- Patients without insurance are expected to pay their balance in full the day of service. In return, we will reduce the balance due by 5%.

- In cases of shared custody and/or divorce/separated parents, the parent/guardian signing below is responsible for the charges incurred.

- If you are 15 or more minutes late for an appointment, the appointment will have to be rescheduled.

- A parent or legal guardian must accompany any child under the age of 18 to all appointments, unless otherwise specified in writing or the family has contacted the office to make special arrangements.

- This policy applies to all appointments and procedures provided by our office staff beginning today and including all future appointments.

I have read, understand and agree to the financial policy of this office and have received a copy upon my request.

Printed Name: _____

Signature: _____ Date: _____

Please sign only one of the sections below. It should be the section that you agree with.

KID GRINS PEDIATRIC DENTISTRY PRIVACY AND CONSENT FORM:

Purpose of Consent: By signing this form, I consent to Kid Grins Pediatric Dentistry's use and disclosure of protected health/dental information to carry out treatment, payment activities, and healthcare operations for my child/children.

I, _____ have received a copy of
(Parent/Legal Guardian Name)

Kid Grins Pediatric Dentistry Notice of Privacy Practices.

_____
Name of Patient

_____
Signature of Parent/Legal Guardian

Date: _____

OR

REVOCATION OF CONSENT:

I revoke my consent for Kid Grins Pediatric Dentistry's use and disclosure of my protected health/dental information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action Kid Grins took in reliance on my consent before receiving this written notice of revocation. I also understand that Kid Grins may decline to treat or to continue to treat my child/children after I have revoked my consent.

I also understand that if I do not include my social security number, Kid Grins will not be able to submit insurance claims for my children. This means that I am responsible to pay, in full, for treatment on the day of service.

_____
Name of Patient

_____
Signature of Parent/Legal Guardian

Date: _____