New Patient Registration Form

Today's Date: _____ Patient (Child's) Name: _____

Date of Birth: _____ Age: _____ Gender (circle): Male Female

School Name: _____ Reason for Visit: _____

Child's Pediatrician: _____ Phone: _____

Your Name: _____ Date of Birth: _____

Your relationship to patient: _____

Street Address: _____ City: _____ State: _____ Zip: _____

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

Email: _____ Driver's License #: _____

Spouse Name: _____ Date of Birth: _____

Preferred contact method? (circle as applicable) E-mail Text Home Phone Cell Phone Work Phone

Emergency contact (other than you): Name: _____

Relationship to Patient: _____ Phone: _____

Besides you, provide 2 alternate adults (over age 18) who are <u>authorized</u> to bring your child to the dentist?

1) Name: _____ Relationship to Patient: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Driver's License #: _____ Date of Birth: _____

2) Name: _____ Relationship to Patient: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Driver's License #: _____ Date of Birth: _____

Referral Source: How did you hear about us? Please be as specific as possible.

- ❑ Pediatrician (specify below)
- ❑ Magazine (specify below)
- ❑ Friend (specify below)
- ❑ Relative (specify below)
- ❑ School (specify below)
- ❑ Insurance (specify below)
- ❑ Google
- ❑ Zocdoc
- ❑ Driving by
- ❑ Facebook
- ❑ Sports and activities
- ❑ Autism Notebook
- ❑ Other (specify below)

Referral/Source Name: _____

Patient Medical and Dental History

Does your child have a history of **ANY** of the following medical conditions below? Please check **ALL** that apply.

- ❑ Heart Disease
- ❑ Cerebral Palsy
- ❑ Organ Transplant
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Seizures/Epilepsy
- ❑ Sickle Cell Disease
- ❑ Hepatitis Type A/B/C
- ❑ Rheumatic Fever
- ❑ Cystic Fibrosis
- ❑ Endocarditis
- ❑ Liver/Kidney Disease
- ❑ Diabetes (Type I or II)
- ❑ Sleep Apnea
- ❑ Abnormal Bleeding/ Hemophilia/Thalassemia
- ❑ History of Cardiac Surgery
- ❑ History of Blood Transfusions/Dialysis
- ❑ Bone Marrow Transplant
- ❑ History of Cancer/Tumors

The conditions in this box may require medical consultation and antibiotic prophylaxis.

- ❑ Innocent Heart Murmur
- ❑ Spina Bifida
- ❑ Asthma
- ❑ Visual/Auditory impaired
- ❑ GI Disorders/Reflux
- ❑ Speech Impediment
- ❑ ADHD
- ❑ Recurrent Ear Infections
- ❑ Autism
- ❑ Whooping Cough
- ❑ Down's Syndrome
- ❑ Eating Disorder
- ❑ Developmental Delay
- ❑ Dizziness/Fainting
- ❑ Psychiatric Illness
- ❑ Genetic Disorder
- ❑ Drug/Alcohol/Tobacco use
- ❑ Pregnant (Currently)

Other medical conditions (please list/explain):

_____

_____

_____

_____

Does your child have any **ALLERGIES** to the following? ❑ NO KNOWN ALLERGIES ❑ Latex ❑ Penicillin

❑ Medications:_____ ❑ Food/Other:_____

Does your child take any medications? ❑ NO ❑ YES, please list:

Has your child ever been hospitalized or had surgeries? ❑ NO ❑ YES, please specify:

Is this your child's first visit to a dentist? ❑ YES ❑ NO, date of last visit: _____

How many times per day does your child brush his/her teeth? ❑ 0 ❑ 1 ❑ 2 ❑ ≥3 Adult Supervision? ❑ Yes ❑ No

How many times per day does your child floss his/her teeth? ❑ 0 ❑ 1 ❑ 2 ❑ ≥3 Adult Supervision? ❑ Yes ❑ No

Has your child ever had any trauma or injuries to the mouth or teeth?

❑ NO PAST TRAUMA/INJURIES ❑ YES, please specify: _____

Does your child currently have any dental pain? ❑ NO PAIN ❑ YES, please specify: _____

Does your child fall asleep with the bottle or sippy cup in his/her mouth? ❑ NO ❑ YES

Does your child have any of the following habits?

- ❑ Thumb/Finger Sucking
- ❑ Lip Biting/Sucking
- ❑ Mouth Breathing
- ❑ Nail Biting
- ❑ Teeth Grinding/Clenching
- ❑ Pacifier Use
- ❑ Snores while sleeping
- ❑ Protrudes Tongue
- ❑ None

Insurance Information

(Note: We do not bill multiple insurances)

Do you have insurance coverage for your child? ❑ Yes ❑ No

❑ I have already provided this information *(skip below fill-in section; read below, sign and date)*

Policy Owner Name:_____ Date of Birth: _____

Insurance Company: _____

Policy Number:_____ Group Number: _____

Insurance Co. Address:_____ City: _____State:_____Zip: _____

Insurance Co. Phone: _____

FOR PATIENTS WITH DENTAL INSURANCE:

I understand that the American Pediatric Dental Group uses all resources available to them to verify my insurance, however, those resources do not provide a guarantee of payment. All claim payments are determined at the time of claim submission. Furthermore, I certify that my child is covered by the above named insurance company and I assign directly to American Pediatric Dental Group all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature and all my insurance submissions, whether manual or electronic. Should the account be referred to any attorney for collection, the undersigned shall pay reasonable attorney's fees and expenses.

PLEASE NOTE:

Payment in **FULL** is expected at the time of dental treatment. The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been made. Since we reserve a special time to offer quality treatment for your child, patients with *two or more* broken or cancelled appointments without a minimum 24-hour notice will result in *discontinuation of any further dental services*, except for 30 days of dental emergencies.

I attest that all of the information provided by me in this New Patient Packet is accurate and correct to the best of my knowledge. I am aware that this information will be kept confidential. It is my responsibility to inform this office of any changes in my child's medical history. I authorize the dental staff to perform any necessary dental services that my child may require.

Name:_____

Signature:_____ Date: _____