DAYTON PEDIATRIC DENTISTRY – NEW PATIENT REGISTRATION

To help us meet all of your child's needs, please fill out these forms completely and accurately.

PATIENT INFORMATION:

Name: _____ Birthdate: _____ Age: _____ Sex: □ F □ M Nickname: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Telephone: _____ Cell: _____
Do we see siblings? □ No □ Yes if yes, please list their names: _____
Whom may we thank for referring you to our office? _____

PARENT/GUARDIAN INFORMATION:

□ Father □ Stepfather □ Guardian Married □ Yes □ No
Name: _____ DOB: _____ SSN# _____
Place of employment: _____ Work #: _____
Home Telephone: _____ Cell: _____
Mailing address (if different than above): _____
□ Mother □ Stepmother □ Guardian Married □ Yes □ No
Name: _____ DOB: _____ SSN# _____
Place of employment: _____ Work #: _____
Home Telephone: _____ Cell: _____
Mailing address (if different than above): _____

INSURANCE:

As a **courtesy** we will accept assignment of benefits from most insurance companies. In order to do so, you must provide the following information:
Do you have dental insurance? □ Yes □ No
Would you like us to bill your insurance? □ Yes □ No
Name of person insured: _____ Relationship to patient: _____
Insured's Social Security # _____ DOB: _____
Place of employment: _____
Insurance Company: _____ Phone #: _____ Group #: _____
Claims Mailing Address: _____

DENTAL HISTORY:

Why is your child here today? _____
Is this your child's first visit to a dentist? □ Yes □ No If no, date of the last visit: _____
Will your child be a cooperative patient? _____
Please describe how you think your child will behave today. Check all that apply:
□ friendly □ happy □ anxious □ timid □ afraid □ resistant
Does or did your child receive fluoride in any form? □ Yes □ No Please describe: _____
Has your child inherited any dental characteristics? _____
Have there been any injuries to your child's teeth? _____
Place a check in the square below if your child has or has had any of the following problems:

□ Cavities	□ Toothache	□ Bad Breath
□ Crooked Teeth	□ Sensitive to Sweets	□ Bleeding Gums
□ Sensitive/hot/cold	□ Frequent Headaches	□ Discolored Teeth
□ Loose Teeth	□ Teeth Bumped	

Does your child have any of the following oral habits?

□ Thumb Sucking	□ Lip Biting	□ Teeth Grinding
□ Pacifier Use	□ Other _____	

How often does your child brush his/her teeth? _____
Does your child floss his/her teeth? □ Yes □ No
At what age did your child stop using the: Bottle? _____ Sippy cup? _____

PLEASE TURN OVER AND FILL OUT MEDICAL HISTORY PORTION OF THIS FORM.

MEDICAL HISTORY:

Child's Family Physician _____ Address _____ Phone _____
Is your child in good health? □ Yes □ No
If no, please describe: _____
Were there any problems at birth? □ Yes □ No
If yes, please describe _____
Are your child's immunizations and booster shots up to date? □ Yes □ No
Has your child ever been allergic to anything? □ Yes □ No
If yes, what was the drug/food and type of reaction? _____
Has your child had any surgical operations? □ Yes □ No
If yes, for what? _____
Has your child ever been hospitalized? □ Yes □ No
If yes, for what? _____

Has your child had or does he/she now have any of the following? PLEASE CIRCLE YES OR NO:

Allergies/ Sinus problems/ drainage	**Yes**	**No**	Eating disorders	**Yes**	**No**	Steroid therapy or chemotherapy	**Yes**	**No**
Asthma	**Yes**	**No**	Abnormal bleeding/bruising	**Yes**	**No**	Nervous or mental disorders	**Yes**	**No**
Heart trouble or heart murmur	**Yes**	**No**	Blood transfusions	**Yes**	**No**	Convulsions or seizures	**Yes**	**No**
Rheumatic heart disease or fever	**Yes**	**No**	Birth defects	**Yes**	**No**	Frequent diarrhea or vomiting	**Yes**	**No**
Blood diseases or anemia	**Yes**	**No**	Kidney disease	**Yes**	**No**	Mumps, measles, or chicken pox	**Yes**	**No**
AIDS virus	**Yes**	**No**	Cleft lip or palate	**Yes**	**No**	Cancer, tumors, growths, or cysts	**Yes**	**No**
Herpes virus or shingles	**Yes**	**No**	Scarlet fever or high fever	**Yes**	**No**	Tuberculosis or TB exposure	**Yes**	**No**
Diabetes	**Yes**	**No**	High or low blood pressure	**Yes**	**No**	Problems with anesthesia	**Yes**	**No**
Ear, eye, nose or throat trouble	**Yes**	**No**	Liver disease	**Yes**	**No**	Thyroid disease	**Yes**	**No**
Stomach ulcers	**Yes**	**No**	Jaundice or hepatitis	**Yes**	**No**	Down's Syndrome	**Yes**	**No**
Autism/Asperser's/PDD/NOD	**Yes**	**No**	Developmental Delays	**Yes**	**No**			

***If yes, please specify:
_____
_____

CURRENT MEDICATIONS:

Name/ Strength (mg)	**How often?**	**Reason for taking**
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

Do you consider your child to be: □ advanced in learning □ progressing normally □ a slow learner
Child's first language? _____ Second or other languages? _____
Child's favorites (pet, toy, hobby, etc.) _____
How does your child tolerate dental/medical care? _____
_____

AUTHORIZATION AND RELEASE:

I understand that payment of a calculated % is due at the time treatment is rendered and that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to Dayton Pediatric Dentistry any insurance benefits.

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 information, including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to other healthcare practitioners.

WE DO NOT BILL THIRD PARTY INSURANCE CARRIERS

Signature of Parent/Guardian: _____ Date: _____

Printed Name: _____

Dentist's Signature: _____ Date: _____

DAYTON PEDIATRIC DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

FOR UPDATED GUIDELINES EFFECTIVE AUGUST 2014

PATIENTS NAME: _____ DATE OF BIRTH: _____

TO THE PARENT---PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your child's protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have a right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your child's protected health information, and of other important matters about your child's protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's protected health information that we maintain.

Revoke: You will have the right to revoke this Consent at any time by giving us written information of your revocation submitted to the Contact Person listed on the Notice of Privacy Practices. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat your child or to continue treating your child if you revoke this Consent.

SIGNATURES

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

……

EMAILING X-RAYS

In providing the best treatment for our patients, it might be necessary for us to email x-rays to other specialists or dentists. This allows other offices to have a better diagnostic tool available to them which will cost you less and permit you to have access to quicker service.

Signature: _____ Date: _____

Print Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

KYLE HENSLEY, D.D.S.

MATTHEW PINGEL, D.M.D.

GENERAL CONSENT FOR PEDIATRIC DENTAL TREATMENT

PATIENT NAME: _____

DOB: _____

Our office specializes in the dental health of children. We concentrate on prevention of oral disease before it occurs, as well as, attempting to eliminate the fear and pain often associated with dental visits.

Appointments are scheduled according to the patient's age. Children 4 years of age and younger are scheduled in the morning hours only, as they tend to do better when well rested. We ask your full cooperation with this policy.

We ask all patients to accompany the assistant to the treatment area by themselves. We are highly experienced in helping children overcome fear and anxiety. We find most patients are more cooperative when the parent is not present. We will be happy to give progress reports during the procedure and will invite you back for the examination. Please, NO SIBLINGS in the treatment area when the doctor is discussing your child's dental health.

Pain and fear are two common feelings associated with dental visits. We attempt to alleviate these feelings by making the child feel comfortable with the office environment designed for them and with the dental team. In most cases, we develop a positive relationship with the child leaving him/her wanting to return for their next visit.

We use several behavior techniques and pain control such as:

- Explaining the procedure to the child in simple terms
- Topical and local anesthetic (Lidocaine, etc.)
- Nitrous Oxide to relax your child (you will be informed before the use)
- General anesthesia (extreme cases)

CELLULAR PHONES MUST BE TURNED OFF WHEN IN THE TREATMENT AREA

I have read, understand and give permission to the doctors listed above to provide routine dental treatment to my child as he/she deems necessary and appropriate. Please present any questions or concerns you may have to the assistant before your child is seated.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Witness Date

DAYTON PEDIATRIC DENTISTRY

PERSONAL HEALTH INFORMATION DISCLOSURE AGREEMENT

I,_____, do hereby grant permission for Dayton Pediatric Dentistry, to disclose my child's personal health information to the following personal representative(s): (spouse, sibling, friend, child, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Information to be disclosed (please check):

_____ Appointment dates and times also to accompany patient to appointment

_____ Treatment plans and referrals

_____ Financial and billing information

_____ Any other pertinent dental health information related to treatment at this office.

_____ None of the above

……..

I understand that this permission will remain in effect unless a written cancellation has been provided to Dayton Pediatric Dentistry.

_____ _____

Parent Signature Date

_____ _____

Patient's Name Date of Birth

_____ _____

Witness Signature Date

OFFICE POLICY

Thank you for choosing us as your healthcare provider. We are committed to your child's treatment being a positive experience. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to your child's treatment. Dayton Pediatric Dentistry complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

- All patients must complete our "Patient Information Form" before seeing the doctor.
- Payment in full is due before services are rendered, based on estimates only.
- We accept Cash, Check (not posted dated), Visa, MasterCard, Discover, American Express and Care Credit.

Since we are a pediatric practice, the parent or legal guardian is responsible for the minor's account. Also, we appreciate parental concerns and will do what we can to address those concerns. Parents may tour the office to become familiar with the staff and environment on their child's initial visit. However, from that point on, parents will need to stay in our waiting area; this allows the child to develop a rapport with our doctors and staff.

INSURANCE

- As a courtesy to you, we may accept assignment of insurance benefits. The balance is your responsibility, whether or not your insurance company pays.
- We cannot bill insurance unless you bring all insurance information with you. This includes your insurance I.D. card. We request a copy of an original insurance card at each visit.
- Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance of your account will be automatically transferred to you.
- *Please be aware that some, and perhaps all, of the services provided may be a "NON-COVERED" benefit and not considered reasonable and customary under the Medicaid Program and/or other dental insurances.*
- Our fees are determined upon the usual and customary rates for our area. Regardless of the insurance company's determination of usual and customary rates or amount of assignment, *you are required to pay the full amount of charges before services are rendered.*
- When you are a member of an HMO, your obligation is to pay your co-pay and deductible portion at the time of service.

ACCOUNTS

- Our office is not involved in third party billing. Whoever brings the child for a visit is responsible for payment that day.
- Returned checks are subject to a $30.00 service fee and accounts will become cash only basis.
- Balances older than 60 days may be subject to additional collection fees and interest charges of 1.8% per month.
- Should your account become delinquent and placed with a collection agency, you will be responsible for all collection fees and expenses that incur.

MISSED APPOINTMENTS

We understand that occasionally situations may arise to warrant a broken appointment, however; this does leave a serious void in our schedule. We require a 24-hour notice of cancellation be given so that this time can be used for another patient in need of treatment. Therefore, *we reserve the right to charge for an appointment cancelled or missed without 24- hour advance notice. There will be a $35 charge posted to your account for cancelled or broken appointments.* Please help us serve you better by keeping scheduled appointments.

- *Once there is a record of 2 broken appointments, the account will be made inactive and services will no longer be rendered. Cancelled appointments with less than 24 hours notice are considered missed appointments. You may request for records to be transferred to another provider.*

Thank you for understanding our Office Policies. Please let us know if you have any questions or concerns.

"*I understand and agree that regardless of my insurance status coverage, I am ultimately responsible for the balance on my account. In the event that the account would be sent to a collection agency or attorney, I am responsible for all collection fees or charges that may incur."*

Signature of Parent/Guardian _____ Date _____