Patient Registration Form

Patient Information:

Name: _____ Birth date: _____

Preferred Name: _____ SS: _____ Age: _____

Gender: _____ Preferred pronouns: _____

Name of person filling out this paperwork for patient: _____

Relationship to patient: _____

Are you the patient's legal guardian? YES NO

Patient's Guardian Information:

Primary Guardian's Name: _____ DOB: _____ Phone Number: _____

Relationship to Patient: _____

Address: _____

_____

Does the patient live with you? YES NO

Dental History:

Previous Dentist: _____ Date of last dental visit: _____

Is the patient having any current dental/oral pain? YES NO

If yes, please explain: _____

Who brushes the patient's teeth? _____

Does the patient drink sugary liquids (juice, chocolate milk, sweet tea, sports drinks, soda, etc.)? YES NO

Does/Did the patient have braces/orthodontic treatment? YES NO

Has the patient ever needed sedation or general anesthesia for previous dental work? YES NO

Please indicate if your child is experiencing or has experienced any of the following:

- □ Clenching/grinding teeth
- □ Cleft lip/palate
- □ Lip sucking/biting
- □ Nail biting
- □ Going to bed with a bottle or sippy cup
- □ Speech delays/problems
- □ Cavities
- □ Dental anxiety
- □ Swelling, draining infection
- □ Thumb/Finger Sucking
- □ Pacifier
- □ Problems with previous dental work
- □ Injury to the lips, teeth, or jaw
- □ Tonsil/adenoid issues
- □ Other: _____

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What is most important about the patient's relationship with Dr. Jackson? _____

_____

Is there a specific concern you would like Dr. Jackson to address about the patient's teeth or oral health at today's visit?
_____

_____

Medical History:

Patient's primary care physician: _____

Preferred pharmacy: _____

Is the patient currently under the care of a specialist? YES NO

If yes, for what conditions: _____

Current medications including herbal supplements and vitamins: _____

Allergies (drug, food, etc..) : _____

Has the patient ever responded adversely to medical treatment? _____

If yes, please explain: _____

Has the patient ever been hospitalized, had general anesthesia, or been seen in the emergency room? YES NO

Please check if the patient is experiencing or has experienced any of the following:

- □ Abuse
- □ AIDS/HIV
- □ ADD/ADHD
- □ Anemia
- □ Anxiety disorder
- □ Allergies to medications
- □ Artificial heart valves
- □ Artificial Joints
- □ Asthma
- □ Autism
- □ Blood disease
- □ Bleeding disorder
- □ Cancer
- □ Cerebral palsy
- □ Congenital birth defects
- □ Chemical dependency
- □ Developmental delays
- □ Diabetes
- □ Epilepsy
- □ Endocrine/growth issues
- □ General allergies
- □ Headaches
- □ Hearing impairment/loss
- □ Heart Disease
- □ Heart Murmur
- □ Hemophilia
- □ Herpes/fever blisters
- □ Hepatitis
- □ Hypertension
- □ Intellectual disabilities
- □ Jaundice
- □ Kidney Disease
- □ Liver/GI Disease
- □ Radiation Treatment
- □ Respiratory Treatment
- □ Rheumatic Fever
- □ Seizures
- □ Sickle Cell Disease/Traits
- □ Sinus Problems
- □ Special Diet
- □ Spina bifida
- □ Tuberculosis (TB)
- □ Vision disorders
- □ Other: _____

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Does the patient have any special health care needs? YES NO
If yes, please explain: _____

_____

Is there anything else we should know about the patient's medical history? YES NO

If yes, please explain: _____

Primary Insurance: _____ Group #: _____ ID#: _____

Policy Holder's Name: _____ DOB: _____ SS: _____

Relationship to patient: _____ Employer: _____

Secondary Insurance: _____ Group #: _____ ID#: _____

Policy Holder's Name: _____ DOB: _____ SS: _____

Relationship to patient: _____ Employer: _____

CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Star Kids Dentistry and staff to examine, clean and provide dental treatment for my child. I further request and authorize the taking of dental x-rays as may be considered necessary by Star Kids Dentistry to diagnose and/or treat my child's dental problem. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Star Kids Dentistry will provide an environment that will help your child learn to cooperate during treatment including praise, explanations and demonstrations of procedures and instruments. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Star Kids Dentistry of any changes in my child's medical status.

Parent/Legal Guardian Signature: _____ Date: _____

OFFICE USE ONLY

I have reviewed the medical/dental information of the patient named herein.

Doctor Signature: _____ Date _____

Patient ID _____

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OFFICE INFORMATION

Appointments:

Please understand that it is important for you to keep your child's scheduled dental appointments to maintain optimal dental health. Postponing treatment could compromise the child's condition resulting in discomfort and additional treatment.

The patient's appointment time is set-aside especially for the patient. We strive to stay on time and ask you to be on time for the scheduled appointment. We ask that if you have a change in your schedule and wish to change appointments, please contact our office 48 hours in advance so that we can schedule another appointment for the patient as soon as possible. Repeated cancellations or broken appointments without a 48 hour notice could result in a broken appointment charge or no reappointment.

Payment:

We realize that many families are in a state of change. The policy in our office is that the guardian who presents with the patient for treatment is responsible for payment.

Insurance:

We will file your claim as a courtesy at no charge. We will estimate a portion that insurance typically pays with the understanding that your plan could pay more or less. Any difference between our estimate and the amount actually paid is due from the patient/patient's guardian. We will inform you of this amount.

Patient Consent and Authorization:

I affirm that the above information I have given is correct to the best of my knowledge and will be used for treatment, billing, and processing of insurance claims. I will not hold my dentist or any staff members responsible for any omissions or errors that I may have made in the completion of this form. I understand that it is my responsibility to inform the office of any changes in the patient's medical status. I authorize the dental staff to perform the necessary services that the patient may need. I assign the doctor all insurance benefits. I understand that I am responsible for all costs of dental treatment, or any services rendered.

Guardian Signature: _____ Date: _____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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

Notice of Privacy Practices: You have the 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 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, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by requesting it from us or print the online version.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation. 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 will decline to treat you or to continue treating you if you revoke this consent.

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 protected health information as described in the "Notice of Privacy Practices."

Parent/Legal Guardian Signature: _____Date: _____