PATIENT REGISTRATION

smiez pediatric dental group

PATIENT INFORMATION

CHILD'S FIRST NAME	CHILD'S LAST NAME	CHILD'S MIDDLE INITIAL	DATE

RESPONSIBLE PARTY INFORMATION

Primary Insurance Policy Holder
Parent or Guardian

NAME
ADDRESS
BIRTH DATE
SOCIAL SECURITY NUMBER
DRIVERS LICENSE NUMBER
PRIMARY PHONE
EMAIL
EMPLOYER
EMPLOYER PHONE
DENTAL INSURANCE CO.
MEMBER ID

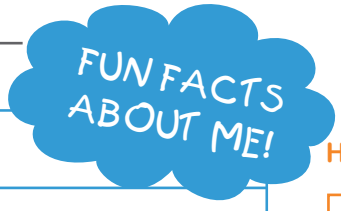
Secondary Insurance Policy Holder
Other Parent or Guardian

NAME
ADDRESS
BIRTH DATE
SOCIAL SECURITY NUMBER
DRIVERS LICENSE NUMBER
PRIMARY PHONE
EMAIL
EMPLOYER
EMPLOYER PHONE
DENTAL INSURANCE CO.
MEMBER ID

EMERGENCY CONTACT

NAME _____ RELATIONSHIP TO PATIENT _____

PRIMARY PHONE _____



SCHOOL	GRADE
SPORTS/ACTIVITIES	
FAVORITE FOOD	FAVORITE COLOR
SPECIAL INTERESTS	

HOW DID YOU HEAR ABOUT US?

- ☐ Mailer
- ☐ Insurance Company
- ☐ Friend: _____
- ☐ Other: _____

PEDIATRIC MEDICAL AND DENTAL HISTORY *please write clearly*

CHILD'S NAME	BIRTH DATE	TODAY'S DATE

HOME PHONE	CELL PHONE	EMAIL

DENTAL HISTORY

Is today your child's first visit? Y N

If NO, how long since your child's last dental visit?

Which dental practice did your child go to?

Date of last dental visit

Date of last cleaning/flouride

Date of last x-ray

Any unhappy dental experiences? If YES, please explain Y N If YES:

Has your child complained about dental problems? Y N If YES:

What brings you to the dental office today?

Does your child brush daily? Y N If YES:

Does your child floss everyday? Y N If YES:

Is flouride taken in any form? Y N If YES:

Any injuries to mouth, teeth, head? Y N If YES:

Does your child have or do any of the following?

Thumb/Finger Sucking	Y N	Pacifier	Y N	Nail Biting	Y N	Lip Biting/Tongue Thrusting	Y N
Nursing/Bottle Habits	Y N	Breast Feeding	Y N	Grinding/Clenching	Y N	Sippy Cup with Sugary Liquids	Y N
Sugary Drinks (Juice/Soda/ Gatorade)	Y N	Sugary Snacks/Chips/ Crackers	Y N				

Does your child play sports? Y N If YES:

If YES, do they currently wear a mouth guard? Y N

MEDICAL HISTORY

Who is your child's primary care physician? (Name & Number)

Date of last exam?

Are your child's immunizations up to date? If NOT, which ones and why? Y N If NOT:

Is your child currently under a physician's care for any medical, emotional or behavioral conditions? Y N If YES:

Was your child born prematurely? Y N If YES:

Did your child spend time in the neonatal ICU after birth? Y N If YES:

Has your child ever had surgery? If YES, please explain. Y N If YES:

Has your child ever been hospitalized for any medical condition or because of significant injury? If YES, please explain. Y N If YES:

Does your child take any prescription or OTC medicines? If YES, please list. Y N If YES:

Does your child have any allergies to medications, latex, food or metals? If YES, please list. Y N If YES:

Does your child have any of the following?

ADHD	Y N	Anemia	Y N	Artificial Joints	Y N	Artificial Heart Valve	Y N
Anaphalaxis	Y N	Asthma	Y N	Autism	Y N	Bleeding Disorder	Y N
Cancer	Y N	Cleft Lip & Palate	Y N	Chemotherapy	Y N	Cold Sores/Fever Blisters	Y N
Developmental Disabilities	Y N	Diabetes	Y N	Eating Disorder	Y N	Emotional Disorder	Y N
Epilepsy or Seizures	Y N	Heart Murmur	Y N	Hearing/Speech Problems	Y N	Heart Disease	Y N
Hepatitis B or C	Y N	HIV/AIDS	Y N	Hydrocephalus	Y N	Kidney Disease	Y N
Liver Disease	Y N	Leukemia	Y N	Lung Disease	Y N	Rheumatic Heart Fever	Y N
Radiation Treatment	Y N	Rheumatism	Y N	Sickle Cell Disease	Y N	Sleep Disorder	Y N
Spina Bifida	Y N	Stomach/Intestinal Problems	Y N	Thyroid Disease	Y N	Tuberculosis	Y N
Tonsilitis	Y N	Tumors or Growths	Y N				

Do any of the conditions above need further explanation? Y N If YES:

Has your child ever had any illness or medical conditions not listed? If YES, please explain. Y N If YES:

COMMENTS

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 (or patient's) health. It is my responsibility to infom the dental office of any changes in medical status.

SIGNATURE of Patient, Parent or Guardian	DATE

PRETREATMENT ASSESSMENT FORM PART 1
To be completed by Parent or Caregiver

DATE

CHILD'S NAME	SIBLING ORDER
DIAGNOSIS	
PREVIOUS DENTAL EXPERIENCES	

The Patient Needs (Check Whichever Apply)

_____ Routine Exam
_____ A Filling
_____ A Cleaning
_____ "A Lot of Work"
_____ Orthodontic Treatment
_____ An Extraction
_____ Not Sure, But Seems to Be In Pain
_____ Don't Know

The Patient's Level of Cooperation is Likely to Be:

_____ Age Appropriate
_____ Playful
_____ Non-Focused
_____ Wiggly
_____ Aggressive
_____ Short Attention Span
_____ Combative
_____ Don't Know

Management Techniques I Would Like the Doctor to Use

_____ Sedation
_____ Short, Multiple Visits
_____ Restraint
_____ Operating Room/General Anesthesia
_____ Don't Know

Regarding Whether You Stay with the Patient or Stay in the Waiting Room
Please circle whether you agree or disagree with the following:

AGREE	DISAGREE	It is best if I stay with the Patient because the Patient needs me there.
AGREE	DISAGREE	It is best if I stay with the Patient because I can help the Doctor and the Staff.
AGREE	DISAGREE	It is best if I stay with the Patient because I need to be there.
AGREE	DISAGREE	It is best if I wait in the Waiting Room because Dentists make me nervous, and that won't help the situation.
AGREE	DISAGREE	It is best if I wait in the Waiting Room because the Doctor knows best how to handle the Patient's behavior in the dental environment.

Things I know will motivate the Patient to try harder. (e.g. computer time, DVD, ice cream, etc.)

Any other information that the Staff should know prior to working with this Patient.

HIPAA NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

SmileZ Pediatric Dental Group, 24565 Dulles Landing Drive, #150, Dulles, VA 20166

I hereby acknowledge that I have read and received a copy of the attached dental practice's HIPAA Notice of Privacy Practices of SmileZ Pediatric Dental Group.

PRINT NAME	
SIGNATURE	DATE

If not signed by patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

FOR OFFICE USE ONLY:

Signed Form Received By: _____

Acknowledgment Refused: _____

Efforts to Obtain: _____

Reason for Refusal: _____

ACKNOWLEDGEMENT OF PRIVACY NOTICE

SmileZ Pediatric Dental Group will use and disclose your personal health information to treat you, to receive payment for care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to protected health information. The terms of this notice may change with time and we will post the current notice at our facility and have copies available for the distribution. I acknowledge I have received, read and understand the NOTICE OF PRIVACY PRACTICES.

I also give **SmileZ Pediatric Dental Group** permission to speak to the following people (if any) regarding my child's health information:

_____ _____

_____ _____

PRINT PATIENT'S NAME	
PARENT/GUARDIAN SIGNATURE	DATE

FINANCIAL POLICY & DENTAL INSURANCE

Dear Parent or Guardian,

Thank you for choosing our office for your child's dental needs. We always strive to provide quality dentistry with compassion in a comfortable and friendly atmosphere. We hope that you and your family will feel welcome at all times. We would like to acquaint you with our policies regarding dental insurance, financial arrangements and schedule changes.

We do not want finances to be an issue for our patients. We want you to fee comfortable with us, and that includes feeling satisfied with your financial arrangement regarding your child's preventative and restorative dentistry. We encourage you to enter into a financial arrangement that is comfortable for you. For your ease and convenience, we offer several types of financial arrangements for out-of-pocket costs. Unless financial arrangements are made, payment is due at time of service.

- We offer comfortable financing through **Care Credit** which offers up to 12 months **NO INTEREST** financing as well as long term plans with low interest rates. You must qualify to use any of the plans offered by **Care Credit**. Please do not hesitate to ask us about this option. We will conveniently qualify you right here in the office today.
- **We accept Visa, MasterCard, Discover and American Express, check and cash.**

Dental Insurance

- Dental Insurance - **As a courtesy to you,** if you have dental insurance we will complete your insurance form with all necessary information and submit it to the primary insurance company. Your co-payment will be estimated and is due at the time of service unless other arrangements are made with this office. **Unless we are a participating provider with the carrier, any secondary coverage is the responsibility of the insured.**
- If your insurance company has not made a payment within 60 days of billing, the balance will become your responsibility. You will be billed for any balance due. Insurance coverage is a contractual agreement between the insurance company and you and/or your employer. We have no control over this relationship. **Again, unless we are a participating provider with the carrier, and secondary coverage is the responsibility of the insured.**

All accounts with an outstanding balance will receive a statement each month. We reserve the right to charge any outstanding balance over 25 days a finance charge of 1.5 (18% APR).

Please understand that we take the time that we have scheduled for your child and your child's dental health very seriously and we hope for the same consideration. As a courtesy, we attempt to remind our patients of their appointment by phone call and ask for a confirmation response. However, we hope that our patients do not replay solely on our courtesy reminders. *Therefore, we reserve the right to charge for appointments broken without the proper 24 hours or 1 business day's notice.*

I authorize and release information to and payment of my child's dental benefits to the dentist. I have read and understand fully my financial options and obligations. I understand that in the even my account becomes delinquent I will be responsible for any collections, attorney fees at 33.3% court costs and any other charges incurred to collect this account. Additionally, by signing this form hereby authorize Smilez Pediatric Dental Group to process Credit Card transactions initiated by me either by mail or phone and authorize my credit institution to pay.

PRINT PATIENT'S NAME	
PARENT/GUARDIAN SIGNATURE	DATE