DAVID L. ROTHMAN, DDS
PEDIATRIC DENTISTRY



# CHILD'S REGISTRATION AND HISTORY

Complete forms, print out and sign. Bring completed forms to your office visit.

Child's Name: Nickname:

Sex: ☐ Male ☐ Female Birthdate: Age:

School:

Is this your child's first dental visit? ☐ Yes ☐ No

Is this an emergency visit? ☐ Yes ☐ No

If no, name of former dentist?

Date of last visit: Purpose:

Have any other children in your family been a patient in this office? ☐ Yes ☐ No

If yes, names:

Has your child had any bad dental experiences? ☐ Yes ☐ No

If yes, explain:

Please check any of the following which may describe your child:

| | | | |
|---|---|---|---|
| ☐ Outgoing | ☐ Shy | ☐ Stubborn | ☐ Anxious |
| ☐ Frightened | ☐ Defiant | ☐ Suspicious | ☐ Moody |
| ☐ High Strung | ☐ Regular Kid | ☐ Friendly | ☐ Cooperative |

Name of child's pet:

Favorite Interest: Favorite Sport:

How do you expect your child to react to his/her visit today?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

How may we help to make this a positive experience for your child?

Name of family dentist:

Whom may we thank for referring you to our office?

Child's Pediatrician:

Date of last physical: Phone:

Address:

My child is foster/adopted and has lived with me for years

Is your child in good health? ☐ Yes ☐ No

Are your child's immunizations up to date? ☐ Yes ☐ No

Is your child being treated for any condition presently? ☐ Yes ☐ No

If yes, explain:

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No

If yes, explain:

Does your child have any allergies or reactions to any medications? ☐ Yes ☐ No

If yes, explain:

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# CHILD'S REGISTRATION AND HISTORY — continued

Has your child ever been diagnosed as having any of the following conditions?

- ☐ Acid Reflux
- ☐ ADD/ADHD
- ☐ AIDS
- ☐ Allergies to Medication
- ☐ Anemia
- ☐ Asthma
- ☐ Autism
- ☐ Bladder Conditions
- ☐ Blood Transfusions
- ☐ Birth Defects
- ☐ Bone or Joint Problems
- ☐ Brain Injury
- ☐ Bruising Easily
- ☐ Cancer or Malignancies
- ☐ Cerebral Palsy
- ☐ Child Abuse
- ☐ Chronic Adenoid\Tonsil Infection
- ☐ Chronic Headaches
- ☐ Chronic Ear Infections
- ☐ Cleft Lip/Palate
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eye Problem
- ☐ Excessive Bleeding Problem
- ☐ Excessive Gagging
- ☐ Fainting or Dizziness
- ☐ Growth and Development Problems
- ☐ Hearing/Speech Problems
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis or Liver Disease
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Mental/Emotional Disturbances
- ☐ Nutritional Deficiency
- ☐ Oral Ulcers
- ☐ Orthopedic Problems
- ☐ Premature Birth
- ☐ Rheumatic Fever
- ☐ Scoliosis/Spine Problems
- ☐ Sickle Cell Anemia
- ☐ Sleep Disorder/Obstructive Sleep Apnea
- ☐ Spina Bifida
- ☐ Syndrome
- ☐ Tuberculosis
- ☐ Other:

Please describe any current or pending medical treatment including drugs, recent injuries or any other information I should be aware of that has not been covered:

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# CHILD'S REGISTRATION AND HISTORY — continued

## DENTAL INFORMATION

Was your child breast fed? ☐ Yes ☐ No If yes, until what age? _____

Has your child had any injuries to his teeth, mouth, head or jaw? ☐ Yes ☐ No

Does your child brush daily? ☐ Yes ☐ No

Does an adult assist with the brushing? ☐ Yes ☐ No

Does your child floss daily? ☐ Yes ☐ No

Does an adult assist with the flossing? ☐ Yes ☐ No

Does your child have any of the following oral habits:

☐ Finger Sucking ☐ Pacifier ☐ Lip Sucking
☐ Teeth Grinding ☐ Thumb Sucking ☐ Tongue Thrusting
☐ Mouth Breather ☐ Other _____

Does your child receive fluoride in any of the following forms:

☐ Vitamins ☐ Water Supply ☐ Tablets/Drops
☐ Toothpaste ☐ Rinse/Gel Dosage: mg/day

## PARENT/GUARDIAN INFORMATION

| Parent Full Name | Parent Full Name |
|---|---|
| Relationship | Relationship |
| Social Security Number | Social Security Number |
| Birthdate | Birthdate |
| Address | Address |
| City | City |
| State Zip | State Zip |
| Phone | Phone |
| Email | Email |
| Employer | Employer |
| Occupation | Occupation |
| Business Phone | Business Phone |

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other

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# CHILD'S REGISTRATION AND HISTORY — continued
## FOR PATIENTS COVERED BY INSURANCE

| | |
|---|---|
| Primary Carrier | Secondary Carrier |
| Address | Address |
| City | City |
| State Zip | State Zip |
| Group Policy Number | Group Policy Number |
| Kck`cp GB | Kck`cp GB |
| How long have you had this coverage? | How long have you had this coverage? |
| years | years |

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.

| | |
|---|---|
| I have reviewed the following treatment plan. | I have reviewed the following treatment plan. |
| I authorize the release of any information relating to this claim. | I authorize the release of any information relating to this claim. |
| I authorize payment of the dental benefits directly to the dentist. | I authorize payment of the dental benefits directly to the dentist. |
| SIGNATURE, PATIENT OR PARENT (IF MINOR) | SIGNATURE, PATIENT OR PARENT (IF MINOR) |

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# FINANCIAL POLICY

Please complete all pages, print out, sign and bring with you to your office visit.

Thank you for choosing us as your child's dental health care provider. We are committed to your child's treatment being successful. Please understand that payment of your bill is considered a part of the treatment. The following is a statement of our financial policy which we require you to read and sign prior to treatment.

**Our policy is as follows**

- Full payment is due at the time of service
- We accept cash, checks, or VISA / MasterCard
- We offer an extended payment plan with prior credit approval

**Regarding Dental Insurance**

We may accept assignment of insurance benefits for your child's visit. However, we do require full payment of deductible and / or co-payment at time of each service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your full insurance information. Please understand that your insurance policy is a contract between you and your insurance company and reimbursement levels are dependent upon the premiums you pay and the benefits your company negotiates. We are not a party to that contract. In the event that we do accept assignment of benefits and your company has not paid within 45 days, you will be responsible for the total amount of your balance.

Please be aware that some, and perhaps all of the services provided may be non-covered and not considered reasonable and necessary by your insurance company.

**Usual and Customary Rates**

Our practice is committed to providing the best possible dental and oral health care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of "usual and customary fees." Insurance companies may calculate their usual and customary by determining limitations on the extent or nature of treatment of services that may be provided for your child.

**Responsibility for Fees**

The adult accompanying a patient and the parents (or guardians, legal or otherwise) are responsible for full payment.

**Missed Appointments**

Because time is reserved for your child, a fee of $50 will be assessed for a missed appointment not canceled at least 24 hours in advance. Please help us serve your child better by keeping scheduled appointments.

**Binding Arbitration**

Binding third party arbitration will be the method for resolving disagreements outlined in any section of this "Financial Policy."

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We are happy to provide any answers and are committed to making your child's and your visit as pleasant and educational as possible.

**I have read, understand and agree to this Financial Policy.**

SIGNATURE OF REPONSIBLE PARTY DATE

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# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: Social Security :

Address:

Telephone: E-mail:

Patient :

**SECTION B: TO THE PATIENT** – Please read the following statements carefully.

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, and of other important matters about 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. 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 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 contacting Rothman Pediatric Dentistry, information at left.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to our office listed at left. 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 you or to continue treating you if you revoke this Consent.

SIGNATURE

I, (your name) , 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 to carry out treatment, payment activities and health care operations.

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SIGNATURE DATE

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

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