CHILD'S REGISTRATION AND HISTORY

Children's Dentistry

PIN

DATE _____

CHILD

CHILD'S NAME _____ NICKNAME _____

DATE OF BIRTH _____ AGE _____ SEX: M F GRADE _____ SCHOOL _____

RESIDENCE ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____

DAD

FATHER'S FULL NAME _____ FATHER'S SOCIAL SECURITY # _____

DATE OF BIRTH _____

FATHER EMPLOYED BY _____ OCCUPATION _____ HOW LONG _____

FATHER'S BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

FATHER'S HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

MOM

MOTHER'S FULL NAME _____ MOTHER'S SOCIAL SECURITY # _____

DATE OF BIRTH _____

MOTHER EMPLOYED BY _____ OCCUPATION _____ HOW LONG _____

MOTHER'S BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

MOTHER'S HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

FAMILY

OTHER CHILDREN IN YOUR FAMILY (Names, ages) _____

ARE THEY CURRENTLY PATIENTS HERE? ❑ YES ❑ NO

NAME AND PHONE NUMBER OF NEAREST RELATIVE OR FRIEND IN CASE OF EMERGENCY _____

_____

INSURANCE

DO YOU HAVE DENTAL INSURANCE? ❑ YES ❑ NO
WHICH PARENT IS THE PRIMARY INSURANCE CARRIER? ❑ FATHER ❑ MOTHER

INSURANCE COMPANY _____

POLICY

INSURANCE POLICY

WE FILE YOUR PRIMARY INSURANCE AS A COURTESY. YOUR PORTION WILL BE REQUIRED AT EACH VISIT. KEEP IN MIND, YOUR PORTION IS ONLY AN ESTIMATE THEREFORE, YOU ARE ULTIMATELY RESPONSIBLE FOR WHATEVER YOUR INSURANCE DOES NOT PAY. IF WE HAVE NOT VERIFIED YOUR INSURANCE PRIOR TO YOUR VISIT, PAYMENT IS DUE IN FULL. AN ITEMIZED RECEIPT WILL BE FURNISHED FOR YOUR DIRECT REIMBURSEMENT FROM YOUR INSURANCE COMPANY.

NON-INSURANCE POLICY

TO REDUCE THE INCREASING COST OF BILLING, PAYMENT IS REQUIRED AT THE TIME SERVICES ARE RENDERED. THANK YOU FOR YOUR COOPERATION.

REFERRAL

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

IF PERSONAL REFERRAL, PLEASE INDICATE CHILD'S NAME _____

OVER

Children's Dentistry

DENTAL

PLEASE ANSWER ALL QUESTIONS:	YES	NO
IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST?	❑	❑
IF NO, WHAT IS THE DATE OF LAST DENTAL VISIT?_____		
WHAT WAS DONE PREVIOUSLY (FILLINGS, EXTRACTIONS, SPACE MAINTAINER, ETC.)?_____		
DOES CHILD HAVE A TOOTHACHE? IF YES, WHEN? (WHILE EATING) (AT NIGHT) (SPONTANEOUS) (WAKE FROM SLEEP)?	❑	❑
AT WHAT AGE WAS CHILD OFF THE BABY BOTTLE?_____		
DOES CHILD BRUSH HIS OR HER TEETH DAILY?	❑	❑
DO YOU ASSIST CHILD WITH TOOTH BRUSHING?	❑	❑
HAS YOUR CHILD EVER HAD A PROBLEM WITH TMJ OR TMD?	❑	❑

	YES	NO
IS YOUR WATER FLUORIDATED AT HOME?	❑	❑
DOES YOUR CHILD TAKE FLUORIDE SUPPLEMENTS?	❑	❑
IS DENTAL FLOSS USED?	❑	❑
DOES CHILD HAVE ANY UNUSUAL SPEECH HABITS?	❑	❑
DOES CHILD SUCK HIS OR HER THUMB OR FINGER OR HAVE ANY SIMILAR HABITS?	❑	❑
WILL CHILD BE UNCOOPERATIVE? IF YES, EXPLAIN.....	❑	❑
HAS THE CHILD EVER HAD ANY UNFAVORABLE DENTAL EXPERIENCES? IF YES, EXPLAIN.....	❑	❑

MEDICAL

CHILD'S PEDIATRICIAN_____ PHONE# _____

DATE OF LAST PHYSICAL EXAM _____ RESULTS _____

PLEASE ANSWER ALL QUESTIONS:	YES	NO
DOES CHILD HAVE A HEALTH PROBLEM?	❑	❑
HAS CHILD BEEN ILL RECENTLY?	❑	❑
HAS CHILD BEEN UNDER TREATMENT BY A PHYSICIAN RECENTLY?	❑	❑
IF YES, FOR WHAT REASON? _____		
HAS CHILD EVER BEEN A PATIENT IN A HOSPITAL?	❑	❑
IF YES, FOR WHAT REASON? _____		
DOES CHILD TAKE ANY MEDICINES? IF YES, WHAT KIND....	❑	❑
_____ WHAT DOSE? _____		
HAS CHILD EVER REACTED TO ANY MEDICINE, SUCH AS PENICILLIN, ASPIRIN, LOCAL ANESTHESIA (DENTAL INJECTION)?	❑	❑

	YES	NO
IS CHILD ALLERGIC TO ANYTHING? (FOOD, POLLEN, ANIMALS, DUST) IF YES, WHAT.....	❑	❑
DOES CHILD HAVE ASTHMA?	❑	❑
DOES CHILD HAVE A HEART PROBLEM?	❑	❑
DOES CHILD BLEED EXCESSIVELY WHEN CUT?	❑	❑
DOES CHILD HAVE AN EMOTIONAL, MENTAL OR NERVOUS PROBLEM?	❑	❑
IS CHILD EITHER PHYSICALLY OR MENTALLY HANDICAPPED?	❑	❑
DOES CHILD HAVE GOOD PHYSICAL COORDINATION?	❑	❑
HAS CHILD EVER HAD A BLOOD OR BLOOD PRODUCT TRANSFUSION?	❑	❑
HAS YOUR PHYSICIAN EVER CAUTIONED YOU AS TO SOME ASPECT OF YOUR CHILD'S HEALTH?	❑	❑

HAS CHILD EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?:

- ❑ HEART DISEASE
- ❑ MALIGNANCIES
- ❑ ANEMIA
- ❑ HEART MURMUR
- ❑ CONVULSION/SEIZURES
- ❑ FREQUENT COLDS
- ❑ HEPATITIS
- ❑ LUNG/BREATHING
- ❑ KIDNEY
- ❑ LIVER
- ❑ EPILEPSY
- ❑ CEREBRAL PALSY
- ❑ CHRONIC SINUS
- ❑ DIABETES
- ❑ T.B.
- ❑ RHEUMATIC FEVER
- ❑ HEMOPHILIA
- ❑ BLEEDING
- ❑ SICKLE CELL
- ❑ CHICKEN POX
- ❑ MUMPS
- ❑ MEASLES
- ❑ VISION
- ❑ HEARING
- ❑ AIDS/HIV POSITIVE
- ❑ FREQUENT/RECURRENT HEADACHES
- ❑ ENDOCRINE (GLANDS)
- ❑ BIRTH DEFECT
- ❑ FREQUENT INFECTIONS
- ❑ STOMACH/G.I.

HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING DISEASES?:

- ❑ DIABETES
- ❑ CANCER
- ❑ HEART DISEASE
- ❑ HEMOPHILIA
- ❑ T.B.
- ❑ AIDS/HIV POSITIVE

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION I SHOULD BE AWARE OF THAT WE HAVE NOT DISCUSSED.

_____

THIS INFORMATION GIVEN BY: _____ RELATION TO CHILD: _____

PARENTAL CONSENT FORM

CONSENT: YOUR CHILD IS A MINOR, THEREFORE IT IS NECESSARY THAT A SIGNED PERMISSION BE OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY NECESSARY DENTAL SERVICE CAN BE STARTED. I GRANT THE DOCTOR PERMISSION TO PROVIDE MY CHILD'S DENTAL EXAM AND TREATMENT AND I WILL BE RESPONSIBLE FOR THE COST OF THIS DENTAL CARE. THE INFORMATION ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNED_____

PARENT OR GUARDIAN

Children's Dentistry

Dental care that's loved by kids

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, Dr. Stepanski will originate and maintain paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I understand and have been provided with a *Notice of Patient Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the ***"Notice"*** prior to signing this consent,
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Please tell us with whom we may discuss your/patient's treatment, payment or healthcare operation:
Example: spouse (name), Children (names), other relatives (names), friends or caregivers (names)

_____

_____

Messages or Appointment Reminders:
May we leave a message/text/email at your **home** using doctor's/practice name: Yes [ ] No [ ]
May we leave a message/email at your **work** using doctor's/practice name: Yes [ ] No [ ]
Messages will be of a non-sensitive nature, such as, appointment reminders.

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers and may be sent/received via the internet. I consent to such disclosure for these uses as permitted by law.

I fully understand and **accept / decline** (please circle one) the information of this consent.

_____ _____

Patient/Guardian Signature Print name of person signing

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. Yes [ ] No [ ]

_____

Date

FOR OFFICE USE ONLY

[ ] " Consent form" received and reviewed by_____ on _____

[ ] " Consent form" signature refused by patient [ ] Restrictions added by patient

[ ] "Consent form" placed in the patient's medical record on _____

WELCOME!

Please share what makes you special...

My name is

_____

I go to school at

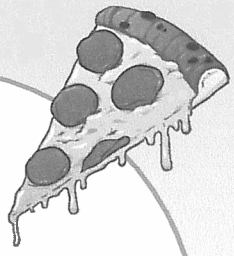
_____

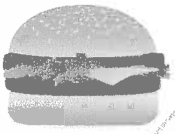
_____

My favorite food is

_____

_____



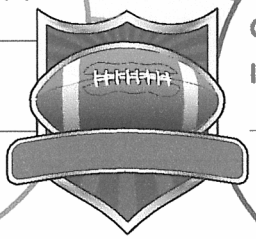


I play musical instrument(s)

_____

I play sport(s)

_____



One place I'd really like to go is

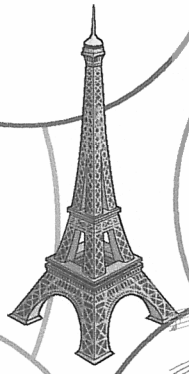
_____

On the weekend I like to

_____

_____

_____



The greatest thing that ever happened to me was

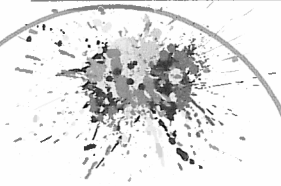
_____

_____

I'm really good at

_____

_____



My favorite color is

_____

I really love to

_____

_____

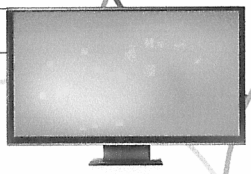
_____

_____

_____

My favorite song or group is

_____



My favorite TV show is

_____

_____

_____

I have a pet named

_____

and it is a

_____