PEDIATRIC DENTAL TEAM

# Welcome to the Pediatric Dental Team!

Registration Form

*Please take a moment to fill out the following so that we can best take care of you:*

Patient's Full Legal Name:_____ Date of Birth:_____

## PARENT/GUARDIAN INFORMATION

Parent/Guardian Full Name:_____ Date of Birth:_____

Home Address:_____

Home Phone:_____ Cell Phone:_____

Email_____ Relationship to Patient:_____

## INSURANCE INFORMATION

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security:_____ Employer Name:_____

Insurance Company:_____

Group Number:_____ Policy Number:_____

## SECONDARY INSURANCE INFORMATION

Policy Holder's Name:_____ Policy Holder's Date of Birth: _____

Policy Holder's Social Security:_____ Employer Name:_____

Insurance Company:_____

Group Number:_____ Policy Number:_____

## EMERGENCY CONTACT INFORMATION

Emergency Contact Person:_____Relationship to Patient:_____

Cell Phone Number:_____

# Pediatric Medical History

Child's legal name _____ Nickname: _____ Date of birth: ____/____/____
Birth sex: ☐ M ☐ F Current gender identity: _____ Race/Ethnicity:_____ Height:_____ Weight:_____
Primary physician:_____ Location:_____ Last visit:_____
Medical specialist:_____ Location:_____ Last visit:_____
Medical specialist:_____ Location:_____ Last visit:_____

| | | |
|---|---|---|
| Is your child being treated by a physician at this time? Reason_____ | ☐ Yes | ☐ No |
| Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? | ☐ Yes | ☐ No |
| List name, dose, frequency and date started:_____ | | |
| Has your child every been hospitalized, had surgery or a significant injury, or been treated in an emergency department? | ☐ Yes | ☐ No |
| List date and describe:_____ | | |
| Has your child ever had a reaction to or problem with an anesthetic? Describe_____ | ☐ Yes | ☐ No |
| Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List_____ | ☐ Yes | ☐ No |
| Is your child allergic to latex or anything else such as metals, acrylic, or dye? List_____ | ☐ Yes | ☐ No |
| Is your child up to date on immunizations against childhood diseases? | ☐ Yes | ☐ No |
| Is your child immunized against human papilloma virus (HPV)? | ☐ Yes | ☐ No |

***Mark "YES" if your child has a history of the following conditions. If "YES," provide details in the box at the bottom of this list. Mark "NO" after each line if none of those conditions applies to your child.***

| | | |
|---|---|---|
| Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions | ☐ Yes | ☐ No |
| Problems with physical growth or development | ☐ Yes | ☐ No |
| Sinusitis, chronic adenoid/tonsil infections | ☐ Yes | ☐ No |
| Sleep apnea/snoring, mouth breathing, or excessive gagging | ☐ Yes | ☐ No |
| Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease | ☐ Yes | ☐ No |
| Irregular heart beat or high blood pressure | ☐ Yes | ☐ No |
| Asthma, reactive airway disease, wheezing, or breathing problems | ☐ Yes | ☐ No |
| Cystic fibrosis | ☐ Yes | ☐ No |
| Jaundice, hepatitis, or liver problems | ☐ Yes | ☐ No |
| Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems | ☐ Yes | ☐ No |
| Food allergies or dietary restrictions | ☐ Yes | ☐ No |
| Concerns with weight or eating disorders | ☐ Yes | ☐ No |
| Bladder or kidney problems | ☐ Yes | ☐ No |
| Scoliosis, limited use of arms or legs, muscle/bone/joint problems, or arthritis | ☐ Yes | ☐ No |
| Rash/hives, eczema, or skin problems | ☐ Yes | ☐ No |
| Impaired vision, visual processing, hearing or speech | ☐ Yes | ☐ No |
| Developmental disorders, learning problems/delays, or intellectual disability | ☐ Yes | ☐ No |
| Seizures/convulsions, epilepsy, Cerebral palsy, brain injury | ☐ Yes | ☐ No |
| Autism/autism spectrum disorder | ☐ Yes | ☐ No |
| Recurrent or frequent headaches/migraines, fainting, or dizziness | ☐ Yes | ☐ No |
| Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) | ☐ Yes | ☐ No |
| Attention deficit/hyperactivity disorder (ADD/ADHD) | ☐ Yes | ☐ No |
| Behavioral, emotional, communication, or psychiatric problems/treatment | ☐ Yes | ☐ No |
| Abuse (physical, psychological, emotional, or sexual) or neglect | ☐ Yes | ☐ No |
| Diabetes, hyperglycemia, or hypoglycemia | ☐ Yes | ☐ No |
| Precocious puberty or hormonal problems | ☐ Yes | ☐ No |
| Thyroid or pituitary problems | ☐ Yes | ☐ No |
| Anemia, sickle cell disease/trait, or blood disorder | ☐ Yes | ☐ No |
| Hemophilia, bruising easily, or excessive bleeding | ☐ Yes | ☐ No |
| Transfusions or receiving blood products | ☐ Yes | ☐ No |
| Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant | ☐ Yes | ☐ No |
| Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), Sexually transmitted disease (STD), or human immunodeficiency virus (HIV/AIDS) | ☐ Yes | ☐ No |

Provide details here: _____

_____

_____

_____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? ☐ Yes ☐ No

_____

_____

PEDIATRIC DENTAL TEAM

If you have a concern about your child's oral health, what is it? _____

How would you describe:

| | | | | |
|---|---|---|---|---|
| your child's oral health? | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| your oral health? | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |
| the oral health of your other children? | ☐ Excellent | ☐ Good | ☐ Fair | ☐ Poor |

Is there a family history of cavities? ☐ Yes ☐ No If yes, indicate all that apply: ☐ Mother ☐ Father ☐ Brother ☐ Sister

Does your child have a history of any of the following? For each YES response, please describe:

| | | | |
|---|---|---|---|
| Inherited dental characteristics | ☐ Yes | ☐ No | _____ |
| Mouth sores or fever blisters | ☐ Yes | ☐ No | _____ |
| Bad breath | ☐ Yes | ☐ No | _____ |
| Bleeding gums | ☐ Yes | ☐ No | _____ |
| Cavities/decayed teeth | ☐ Yes | ☐ No | _____ |
| Toothache | ☐ Yes | ☐ No | _____ |
| Injury to teeth, mouth or jaws | ☐ Yes | ☐ No | _____ |
| Clenching/grinding his/her teeth | ☐ Yes | ☐ No | _____ |
| Jaw joint problems (popping, etc.) | ☐ Yes | ☐ No | _____ |
| Excessive gagging | ☐ Yes | ☐ No | _____ |
| Sucking habit after one year of age | ☐ Yes | ☐ No | If yes, which: ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other ☐ For how long?_____ |

How often does your child brush his/her teeth?_____ times per_____ Does someone help your child brush?... ☐ Yes ☐ No

How often does your child floss his/her teeth? ☐ Never ☐ Occasionally ☐ Daily Does someone help your child floss?.... ☐ Yes ☐ No

What toothpaste does your child use?_____

Is your child on a special or restricted diet? ☐ Yes ☐ No If YES, describe:_____

Do you have any concerns regarding your child's weight? ☐ Yes ☐ No If YES, describe:_____

Has your child been examined or treated by another dentist? ☐ Yes ☐ No

If YES: Date of first visit:_____ Date of last visit:_____ Reason for last visit:_____

Were x-rays taken of the teeth or jaws? ☐ Yes ☐ No Date of most recent dental x-rays:_____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ☐ Yes ☐ No If YES, when?_____

Has your child ever had a difficult dental appointment? ☐ Yes ☐ No If YES, describe:_____

How do you expect your child will respond to dental treatment?.... ☐ Very well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly

Is there anything else we should know before treating your child?... ☐ Yes ☐ No

If yes, describe:_____

_____

## Consents for Today

X-Rays (if needed): Essential for diagnosing tooth decay and other abnormalities..... ☐ YES ☐ NO

Fluoride Application: To help fight tooth decay and strengthen developing teeth..... ☐ YES ☐ NO

Photo and Video Release: I consent and authorize the Pediatric Dental Team and their assignees to take photographs, slides, and videos of my child's teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my child's care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc.)..... ☐ YES ☐ NO

**Signature of parent/guardian:** _____ **Relationship to child:**_____ **Date:**_____

**Signature of staff member reviewing history:**_____ **Date:** _____

**Signature of doctor reviewing history:**_____ **Date:** _____

**Notice of Privacy Practices Acknowledgement Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)**

**Consent/Limited Authorization & Release Form**

You may refuse to sign this acknowledgement and authorization. If you refuse to sign this form, we may not be allowed to process your insurance claims.

The currently effective HIPAA Notice of Privacy Practices for Pediatric Dental Team will be provided to you at your first visit, and is available at the front desk for future reference.

A patient has certain rights to privacy regarding his/her Protected Health Information (PHI). PHI can and will be used to:

- Electronically conduct, plan, and direct treatment and follow up among multiple healthcare providers who may be involved in patient treatment directly or indirectly.
- Electronically obtain payment from third-party payers.
- Electronically conduct normal healthcare operations such as quality assessments and physician certifications.
- The organization has the right to change its Notice of Privacy Practices from time to time and the patient may review these changes at any time by contacting the organization.

The undersigned acknowledges receipt of a copy of the currently effective HIPAA Notice of Privacy Practices. A copy of this signed, dated document shall be as effective as the original. The undersigned acknowledges that his/her signature will also serve as a protected health information document release should he/she request diagnostic or treatment information be sent to another doctor or healthcare facility in the future.

_____ _____

**Patient Name** **Patient Signature**
(Parent/Guardian if patient is under 18)

_____ _____

**Parent/Guardian Name** **Relationship to patient**
(If patient is under 18) (If patient is under 18)
(N/A if patient is over 18) (Examples: “Self”, “Mom”, “Grandfather”, etc.)

I authorize contact from Pediatric Dental Team to **confirm appointments**, **provide treatment and billing information** and **provide health information**, via phone, text, and email.

Signature: _____

Please specify if there are any modes of communication you prefer we NOT use to confirm appointments, provide treatment and billing information and provide health information:_____

Please list any other parties who may have access to your health information (this includes step parents, grandparents, and any other caretaker who you may want to have access to the patient’s records). N/A if these fields do not apply:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____