CHILD'S REGISTRATION AND HISTORY

Date

Child's name | Nickname | Age | Birth date

Residence address | City | State | Zip

School | Address | Grade

Father's name | Mother's name

Father employed by | How long | Home phone | Bus. phone

Mother employed by | How long | Home phone | Bus. phone

Person financially responsible (if other than parent) | Relationship to child

Address | City | State | Zip | Phone

Father's Social Security number | Driver license no. | State

Mother's Social Security number | Driver license no. | State

Father's birth date | Mother's birth date

Credit card name | No. | Expiration date

When dental insurance coverage name of carrier

Secondary insurance coverage, if any

Whom may we thank you for referring you

What is child's favorite: sport | toy | hobby | person | fictional character

DENTAL HISTORY

Date of last visit to a dentist

For what service

Question	Yes	No
Has child complained about dental problems	☐	☐
Any unhappy dental experiences	☐	☐
Any injuries to mouth - teeth - head	☐	☐
Any mouth habits - thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.	☐	☐
Any unusual speech habits	☐	☐
Any lost teeth	☐	☐
Have missing teeth been replaced	☐	☐
Orthodontic appliances worn now or ever been	☐	☐

Question	Yes	No
Does your child brush teeth daily	☐	☐
Do you assist child with tooth brushing / How often	☐	☐
Is dental floss used / How often	☐	☐
Are disclosing tablets used / Is fluoride taken in any form	☐	☐
Do you desire complete dental service for the child	☐	☐
Child's attitude to dentistry	☐	☐
	☐	☐
Summary (for doctor's use)	☐	☐

HEALTH HISTORY

Child's physician ______ Address ______ Phone ______

Date of last physical examination Results ______

	Yes	No
Is child under care of physician now ______	☐	☐
Is child receiving any medication or drugs ______	☐	☐
Is there any excessive bleeding when cut ______	☐	☐
Has child ever been hospitalized ______	☐	☐
Has child ever had surgery ______	☐	☐
Is there any allergy to penicillin or other drugs ______	☐	☐
Are there other allergies: food - pollen - animals - dust - other	☐	☐

	Yes	No
Does child have good physical coordination ______	☐	☐
Are there any emotional problems ______	☐	☐

Summary (for doctor's use) ______

Has child any history of or difficulty with any of the following:

___ Anemia
___ Asthma
___ Bladder
___ Cerebral Palsy
___ Chicken Pox
___ Chronic Sinus
___ Convulsions
___ Diabetes
___ Epilepsy
___ Fainting
___ Hearing
___ Heart
___ Kidney
___ Liver
___ Malignancies
___ Mastoid
___ Measles
___ Mononucleosis
___ Mumps
___ Rheumatic Fever
___ Thyroid
___ Tuberculosis
___ Venereal Disease
___ Other

Summary: (for doctor's use)

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.

______

	Yes	No
May we request release of your child's medical records ______	☐	☐

This information was discussed with and given by ______

Relation to child ______

FINANCIAL AGREEMENT

Our credit policies have been established to ensure that the best services can be provided to you and your family.

Our professional services are rendered to patients, thus patients are responsible for charges for treatments rendered. We are unable to provide services on the assumption that the charges will be paid by the insurance company. The insurance company is responsible to the insured patient. With or without insurance coverage, patients are responsible for full payment of the total bill, unless prior arrangements have been made. ___________ **(initials)**

- The following methods of payment are accepted: Cash, Checks, Visa, Master Card, American Express, Discover Card, Care Credit.
- **Insurance assignment and management:**
  - Patients must provide Penn Valley Dental with accurate/current insurance billing information at the time of their appointment, or they are responsible for payment in full.
  - Insurance benefits are a contract between the patient and his/her employer.
  - **The coverage a patient will receive depends upon the quality of the plan purchased by his/her employer, not the fees of the doctor.**
  - Patients are responsible for paying **their deductible and their co-pay** at the time of service. Patients are also responsible for paying all charges not covered by your insurance plans including all fees considered above their insurance policy's usual and customary fee schedule at the time of service. _______ **(initials)**
  - Patients are responsible for submitting required paper work such as proof of student status to their insurance company. Any balance caused by insurance denial due to missing information is the patient's responsibility.
  - The office will submit a claim up to two (2) times per appointment. Further insurance appeal becomes the patient's responsibility. __________ **(initials)**
  - As an office courtesy, we will accept assignment for the primary insurance coverage. Secondary insurance must be paid to the patient. ___________**(initials)**

- **Patients are responsible for balance in full after 60 days even if their insurance company has not paid. Further insurance appeal becomes the patient's responsibility.** ___________ **(initials)**
- The practice cannot carry balance longer than 90 days. Patients will be informed that their accounts are delinquent before any collection efforts are made.
- Treatments such as root canal therapy, crowns, dentures, and other cosmetic procedures such as whitening require a deposit before treatment is started. The **deposit** amount must be no less than **1/2 of the total cost.** The remaining balance must be **paid in full before final insert and treatment.**
- A service charge of $30.00 will be assessed to your account for any checks returned by your bank.
- **Last minute appointment changes**- Same day and day before cancellations or missed appointments will have a $30.00 charge for every 30 minutes of appointment time scheduled plus one or more hours reserved appointment times will forfeit deposit. The notice must be received Monday thru Thursday. ___________ **(initials)**

I have read and accepted the above Financial Agreement. I understand it, and agree to all payments terms regarding my account.

____

Patient or Parent/Guardian Signature **Date**

H.I.P.P.A. Consent Form

Yes / No — Can we contact you at home? Please list the phone number where we may contact you. (______)______-________

Yes / No — Can we leave a message with a family member? Is there anyone in your home we are not allowed to leave a message with? ____________________________

Yes/ No — May we send a letter or postcard when insurance approvals and or lab work is in?

Please list the name and contact information of the person we may contact in case of emergency below:

Name of person: ___________________________

Relationship:______________________________

Telephone #:(______)______-________

This form is to certify that you have read the notice of our offices privacy practices located by the reception desk. By signing this form you are authorizing us the consent to use and disclose the information in the manner that is described in the fore- mentioned notice.

Print Patient Name:______________________

Signature of Parent/Guardian (if patient is under 18)__________________________________

Date Signed:____/____/_____

Acknowledgement of Receipt of Notice of Privacy Practices

** You may refuse to sign this acknowledgement**

I have received a copy of this office's "Notice of Privacy Practices" and understand that I have the right to opt out of the following.

Optional Information Disclosures

Telephone calls containing general information e.g. "results are negative or within normal limits, scheduling etc" may be left on answering machine or with adult answering the phone. **Yes/NO**

I authorize private dental information to be disclosed to my insurance company as requested. **Yes/NO**

I authorize dental records and dental images/x-rays to be disclosed as considered necessary by my dental provider and this office. **Yes/NO**

Signature:____________________________________ **Date:**____/____/____

You may revoke permission to disclose any of your dental information in the future if necessary by putting it in writing and submitting it to this office.