Catherine V. Marcantonio, DMD
Specialist in Pediatric Dentistry

Michael H. Marcantonio, DMD
General Dentistry

marcantonio DENTISTRY

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Patient Registration Form

Note: Payment is expected at the time of service

Today's Date: _____

Please tell us about your child

Your Child's Name: _____

Nickname: _____

Child's Birthday:_____Age:_____
School:_____Grade:_____

Child's Address:_____

City:_____State:_____Zip:_____

Child's Phone Number: _____

Siblings that we treat: _____

Who may we thank for referring you to our office?

_____

Mother's Information

Name: _____

Mother-Stepmother-Grandmother-Guardian

Birthdate:_____SS#:_____

Employer: _____

Address:_____

City:_____State:_____Zip:_____

Home#_____Work#:_____

Cell#:_____

DL# _____

Email: _____

Father's Information

Name: _____

Father StepFather GrandFather Guardian

Birthdate:_____SS#:_____

Employer: _____

Address:_____

City:_____State:_____Zip:_____

Home#_____Work#:_____

Cell#:_____

DL# _____

Email: _____

Responsible Party:

Name: _____

Relationship to Patient: _____

Address:_____

City:_____State:_____Zip:_____

Primary Insurance Name:

_____

Phone #:_____

Policy #:_____

Group# _____

Policy Holder Name:_____

Secondary Insurance Name:

_____

Phone #:_____

Policy #:_____

Group# _____

Policy Holder Name:_____

Does your child have Medicaid? YES or NO

Who is Accompanying the Child Today?

Name:_____

Do you have legal custody to this child?

_____

Emergency contact other than yourself?

_____

Phone # _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

_____

Signature of Parent or Guardian

_____

Relationship to Patient

Medical History

Have you ever had any of the following?

Y N Abdominal Bleeding
Y N Anemia
Y N Asthma
Y N Cancer/Tumor/Leukemia
Y N Cerebral Palsy
Y N Cleft Lip Palate
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Emotional Problems
Y N Hearing Impairment
Y N Heart Disease Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis/Liver Problems
Y N HIV/AIDS
Y N Hyperactive Disorder
Y N Kidney Disease
Y N Latex/Ribber Allergy
Y N Liver Disease
Y N Malignant Hyperthermia
Y N Pregnancy
Y N Rheumatic/Scarlet Fever
Y N Sickle Cell Anemia/Trait
Y N Speech/Hearing Problems
Y N Thyroid Disorders
Y N Transplants
Y N Tuberculosis
Y N Other

1. Does your child have any drug allergies? _____
2. Please discuss any serious medical conditions the child has had? _____
3. Please list all the medications the child is currently taking; Does? _____
4. Has your child ever had surgery or been hospitalized? Explain. _____
5. Child's Physician: _____ Phone #: (____) _____
6. Are your child's immunizations current? Y N
7. Please describe the child's current physical health. Good Fair Poor

Dental History

What is the reason for your chld's dental visit? _____
Has your child ever been to the dentist? _____ Any unhappy dental experiences? _____
Previous dentist's name _____ Has your child ever had dental x-rays? Date? _____
Have your child's teeth ever been injured? When? How? _____
How do you expect your child to react in the dental chair today? Good Fair Poor
Do you assist/supervise your child's brushing? _____ How often? _____
Do you or your child use dental floss? _____ How often? _____
Was your child bottle fed / breast fed? Has your child been weaned? When? _____
Does your child have snacks between meals? Y N Is your home water supply fluoridated? Y N
Any oral habits: thumb, finger, or pacifier habit? Y N Does your child use a fluoride toothpaste? Y N
Does your child use a fluoride supplement?

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and tit is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of Parent or Guardian **Relationship to Patient**

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials _____ Date _____
Doctor's Comments _____

Dr. Catherine V. Marcantonio, DMD
Specialist in Pediatric Dentistry

Parent Information about
Behavior Management Techniques
For Child Dental Patients

We do our best to give your child the best quality dental care in a safe and caring environment. Every effort will be made to work with your child to gain cooperation through understanding, gentle guidance, humor, and charm. When these fail there are other management techniques that can be used to eliminate or minimize disruptive behavior. Our Dentist(s) and staff have received training in the following techniques accepted by the American Academy of Pediatric Dentistry.

- **Tell-Show-Do**: the dentist or staff member explains to the child what is to be done, shows examples on a tooth model or on the child's finger, then the procedure is done on the child's tooth.
- **Positive reinforcement**: rewards the child who displays cooperative behavior with compliments, praise, a pat on the shoulder, or a small prize.
- **Voice control**: the attention of a disruptive child is redirected by a change in the tone and volume of the dentist's voice.
- **Mouth props**: a padded device is placed in the mouth to prevent closure of the child's teeth on the dentist's fingers or dental equipment.
- **Hand and/or head holding by dentist or assistant**: an adult keeps the child's body still so the child cannot grab the dentist's hand or sharp dental tools.
- **Nitrous oxide**: medication breathed through a colored/flavored nose mask to relax a nervous child. The child remains awake but is relaxed and clam. Nitrous oxide is also known as laughing gas. Children with sensitive stomachs may become nauseated when breathing nitrous oxide.
- **Stabilization wrap**: a body wrap made of fabric mesh and Velcro that is placed around the child to limit movement. It is never used without consent of the parent.

The above behavior management techniques have been explained to me and I have had a chance to ask questions. I understand the what, when, how and why of there use, and the risks/benefits/available alternatives.

_____

Parent/guardian date

Consent for Dental Treatment

I request and authorize Dr. Marcantonio and her staff to examine, clean and provide my child with comprehensive dental treatment including fillings, crowns, extractions and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Marcantonio to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Marcantonio will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I understand that I will be responsible for any charges incurred on this child for dental treatment.

_____

Signature Date

_____

Witness date

Financial Policy

Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. We ask that you pay the cost of the initial examination and any necessary dental x-rays on the day of that appointment. Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following outlines our financial policies:

1. Payment is due in full for each appointment as services are rendered. We accept cash, personal checks, MasterCard, Visa, Discover, and CareCredit. A charge of $35.00 will be assessed on checks returned for any reason. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.
2. Dental Insurance: It is our policy to accept assignment of benefits for dental insurance, provided the insurance carrier pay benefits directly to the doctor. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company; we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. We are currently providers for United Concordia, Delta Dental Premier, and Metlife.
3. Change of Insurance or Self Pay Status: As of August 18, 2010 if your dental insurance or self pay status changes and you become Medicaid eligible, we will not accept Medicaid as a form of payment. However, Dr. Catherine Marcantonio reserves the right to utilize Medicaid in specific situations. Situations in which the child's needs would be best met in a hospital setting. This determination is based on several factors such as severity of decay, age, and behavior.
4. Pre-treatment Authorization: Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.
5. **Fillings: The Dental Material of choice in our office is a white (composite resin) filling. We DO NOT use any restorative material containing mercury (Amalgams). Please be aware that your insurance company may not pay for a resin filling at the same level as silver (amalgam filling). The co-payment is your responsibility. In some cases, the dentist may recommend placing a silver crown instead of a resin filling.**
6. Nitrous Oxide (laughing gas): Nitrous oxide is not always covered by dental insurance. We thank you for your payment at the date of service.
7. Appliances: The entire cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory bills when appliances are ordered, not when they are completed.
8. Emergency Treatment: All emergency treatment must be paid in full at the time the service is rendered.
9. **CANCELATIONS**: You are required to give our office 24 hour notice to cancel appointments. If 24 hours notice is not given then a **$25.00 cancelation fee** will be applied to your account. This fee must be satisfied before you are scheduled for another appointment.
10. **Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. You are helping us keep our overhead expenses, in the form of direct and labor costs, down. In addition, you are helping keep your fees as low as possible. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency. You agree to pay any and all attorney fees associated with the collection of monies due. I have read and understand my obligation.**

Signature:_____Date:_____

Notice of Privacy Practices-HIPPA

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards, emails, or letters).

Patients Rights

Access: You have the right to look at or get copies of your health information. If you request a copy we will charge you for each page for staff time to locate and copy the information, and postage if you want the copies mailed.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.
Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means.
Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. Marcantonio.

Signature: _____Date:_____