CHILD'S REGISTRATION AND MEDICAL HISTORY

Last Name: _____ First name: _____ Nick Name: _____
Home Address: _____ City: _____ State: _____ Zip _____
Home Phone: _____ DOB: _____ Age: _____ Sex: ____Male ____Female
School: _____ Grade: _____
IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? _____ **PHONE:** _____

GUARDIAN OR PARENT'S INFORMATION RESPONSIBLE FOR ACCOUNT

Last Name: _____ First name: _____
Work Phone: _____ Cell: _____ SS#: _____ DOB: _____
Employer: _____ ____Single ____Married ____Widowed ___Divorced
How did you hear about us?: _____

MEDICAL HISTORY

Child's Physician: _____ Phone: _____
Physician's Address _____
Date of last physical examination: _____ Results: _____

Is child under the care of physician now?..... ☐ Yes ☐ No
_____
Is the child receiving any medication or drugs? ..... ☐ Yes ☐ No
_____
Are there any allergies to drugs?..... ☐ Yes ☐ No
_____
Are there any other allergies
(food, pollen, animals, dust, other)? ..... ☐ Yes ☐ No
_____
Are there any emotional or hyperactive problems? ..... ☐ Yes ☐ No

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

Hearing..... ☐ Yes ☐ No
Heart..... ☐ Yes ☐ No
Heart Murmur.. ☐ Yes ☐ No
Kidney..... ☐ Yes ☐ No
Liver..... ☐ Yes ☐ No
Anemia ..... ☐ Yes ☐ No
Asthma ..... ☐ Yes ☐ No

Venereal Disease..... ☐ Yes ☐ No
A.I.D.S. ..... ☐ Yes ☐ No
Convulsions..... ☐ Yes ☐ No
Diabetes..... ☐ Yes ☐ No
Epilepsy ..... ☐ Yes ☐ No
Rheumatic Fever..... ☐ Yes ☐ No

Is there anything else we should know about your medical history? _____
_____
_____

Date: _____ Signature _____

HIPAA Consent

Kent Family Dental
2515 Alpine Avenue, N.W.
Grand Rapids, MI 49544

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such ***Notice of Privacy Practices*** prior to signing this consent. I understand that this organization has the right to change its ***Notice of Privacy Practices*** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices***.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I authorize Kent Family Dental disclose the following initialed protected health information to these individuals:

_____
Name/phone Relation

_____
Name/phone Relation

_____
Name/phone Relation

____ ALL PHI (protected health information) relating to my care.
____ Diagnosis
____ Treatment
____ Appointments
____ Financial arrangements (including insurance/billing)

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Patient Name _____

Date of Birth _____

Kent Family Dental and Your Insurance Plan – HOW THEY WORK TOGETHER

The team at Kent Family Dental is pleased that you have dental benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so we can work together.

Do You Accept My Insurance? How Much Will They Pay?

We currently accept most private care insurance plans, which means we work with literally thousands of companies. Although we maintain computerized histories of payments by a given company, they do change, therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is, ONLY AN ESTIMATE. We will be happy to file a "pretreatment authorization" with your insurance company prior to treatment upon request. This does delay treatment but will give you a more accurate out-of-pocket figure.

I Thought I Paid My Portion, But I Got A Bill. Why?

We base the patient portion of your bill on our most current data, but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies and employers do not notify us of changes to your benefits, they can only notify you. If these situations apply to you, please let us know when we estimate your treatment plan, so we can adjust accordingly.

Insurance Didn't Pay . . . Now What?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, Kent Family Dental reserves the right to request payment in full from you, and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be part of that legal contract. Ultimately, you are responsible for all charges in our office.

PRIMARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____

Relation To Patient _____ SS# _____ DOB _____

Employer Name: _____ ID# _____

Insurance Company Name: _____

SECONDARY DENTAL INSURANCE COVERAGE

Subscriber Name: _____

Relation To Patient _____ SS# _____ DOB _____

Employer Name: _____ ID# _____

Insurance Company Name: _____

I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment at Kent Family Dental.

Signature: _____ Date: _____

2515 ALPINE N.W. • SUITE A • GRAND RAPIDS, MI 49544 • (616) 364-9348