ADVANCED DENTAL CARE
CHILD REGISTRATION FORM

Today's date: (Please Print)

PATIENT INFORMATION

Patient's last name: First: M.I.:			What do you prefer to be called?	
Birth date: / /	Age:	Social Security No.:	Sex: ❑ M ❑ F	Home phone no.: ( )
Parent or Guardian Name:				Relationship to Patient:
Address:		City:	State:	ZIP:
Guardian Employer / Occupation:		Work phone no.: ( )		Cell phone no.: ( )
Referred to office by:	❑ Family/Friend (Name)		❑ Dr.	
	❑ Insurance Plan	❑Internet or Website	❑ Close to home or work	❑ Yellow Pages
Are there any other family members seen in our office (please list):				
EMAIL ADDRESS:				

ACCOUNT INFORMATION

Person responsible for bill:	Address (if different):		Home phone no.: ( )
LA Driver's License Number:	Birth date: / /	Social Security No.:	Employer phone no.: ( )
Employer:	Occupation:		Cell phone no.: ( )

Is this person covered by insurance? ❑ Yes ❑ No	Please indicate **Primary** insurance:			
Subscriber's Name:	Birth date: / /	Subscriber's SSN:	Group No.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone:	Work phone:

1. I hereby authorize doctor/staff to take x-rays, study models, photos, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of this patient's dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks.
4. **I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.** In the event payments are not received by agreed upon dates, I understand that a 1.75% late charge may be added to my account. If required, I also understand a check of my credit history may be made and all collection fees will be passed onto me.
5. **I UNDERSTAND IT IS MY RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES TO THIS PATIENT'S MEDICAL STATUS.**

Patient/Guardian Signature:	Date:

CHILD HEALTH HISTORY QUESTIONNAIRE

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE STRICLY CONFIDENTIAL AND WILL BECOME PART OF YOUR MEDICAL RECORD.

Has the child had any history or, or conditions related to, any of the following:

❑Anemia	❑Chronic Sinusitis	❑HIV + / AIDS	❑Rheumatic Fever
❑Arthritis	❑Diabetes	❑Immunizations	❑Seizures
❑Asthma	❑Ear Aches	❑Kidney	❑Sickle Cell
❑Bladder	❑Epilepsy	❑Latex Allergy	❑Thyroid
❑Bleeding disorders	❑Fainting	❑Liver	❑Tobacco/Drug Use
❑Bones/Joints	❑Growth Problems	❑Measles	❑Tuberculosis
❑Cancer	❑Hearing	❑Mononucleosis	❑Venereal Disease
❑Cerebral Palsy	❑Heart	❑Mumps	❑Other_____
❑Chicken Pox	❑Hepatitis	❑Pregnancy	

Please give details regarding any items checked in the above boxes:

_____

_____

_____

Name of Physician: _____ **Phone no.:** _____

MEDICAL AND DENTAL HISTORY

Is the child taking any prescription and/or over the counter medications or vitamin supplements?	❑Yes ❑No
If yes, please list:	
Is the child allergic to any medications? If yes, please explain:	❑Yes ❑No
Is the child allergic to anything else, such as certain foods? If yes, please explain:	❑Yes ❑No
Has the child ever had a serious illness? If yes, please explain:	❑Yes ❑No
Has the child ever been hospitalized? If yes, please explain:	❑Yes ❑No
Has the child ever received local or general anesthetic?	❑Yes ❑No
Please describe any complications that arose, if any.	
Does the child have speech difficulties?	❑Yes ❑No
Is the child physically, mentally, or emotionally impaired?	❑Yes ❑No
Is the child currently being treated for any illnesses?	❑Yes ❑No
Is this the child's first dental visit?	❑Yes ❑No
If not, when was the date of the last dental visit?	
Has the child ever had dental radiographs (x-rays) exposed?	❑Yes ❑No
Has the child ever suffered any injuries to the mouth, head or teeth?	❑Yes ❑No
Has the child had any problems with eruption or shedding of teeth?	❑Yes ❑No
Has the child had any orthodontic treatment?	❑Yes ❑No
How many times per day are the child's teeth brushed? _____ When are the teeth being brushed? _____	
What does the child drink the most of? ❑Sodas ❑Juice ❑Milk ❑Water ❑Other: _____	
How would you describe the child's eating habits?	
Does the child suck his/her thumb, fingers or pacifier?	❑Yes ❑No
Does the child participate in any recreational activities?	❑Yes ❑No

NOTE: Both doctor/staff and patient are encouraged to discuss any and all relevant patient health information prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist, or any other members of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent/Guardian Signature:_____ Date: _____

GENERAL CONSENT FOR PATIENTS UNDER 18 YEARS OF AGE

In order for us to treat your child, it is necessary that we have consent from the parent or guardian. This is to certify that I, the undersigned, consent to the performance of any and all procedures, including the use of any and all drugs or medications, that are agreed to be necessary or admissible for treatment on _____.
Name of Patient

This agreement also states that I, the undersigned, am the legal guardian of the above mentioned patient. I understand that it is my responsibility to inform this office of any change in custody before any dental treatment is rendered. I also understand that it is my responsibility to inform this office and give consent if someone other than myself brings the child to any visit at this dental office.

_____ _____
Signature of Parent/Guardian Date

Please list below any additional people that are allowed to consent to dental treatment or bring your child to future dental visits.

Name Relationship to Patient

_____

_____

HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent, I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct and indirect treatment by other healthcare providers not involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____ _____
Today's Date Print Patient Name

_____
Signature of Patient or Parent/Guardian

BROKEN APPOINTMENT POLICY

I understand that a fee will be charged for appointments missed without a 24 hour notice given. This fee will start at $50, depending on the length of my appointment time.

Patient Name:_____ Today's Date: _____

Credit Card Number: _____ VISA MC AMEX DISC Expiration Date: _____

Signature of Patient or Parent/Guardian: _____