Patient Registration And History

I. Patient Information:

Name:

(last) (first) (middle) (preferred name)

Child's Home Address | Home Phone | With Whom Does Child Live

Age | Date of Birth | Gender (Male or Female)

Attends what school | Grade | List siblings and ages

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II. Dental History

Is this your child's first dental visit?_____Yes/ No
Name of previous dentist_____
Date of last visit to a dentist_____
For what service_____
Reason for referral_____
Any mouth habits – thumbsucking, nail biting, mouthbreathing, snoring, nursing or bottle habits, pacifier, etc. (circle/explain)?_____ Yes/No
_____
Has child complained about dental problems?____ Yes/No
Explain_____
Any unhappy dental experiences ?_____Yes/ No
Explain_____
Any injuries to mouth, teeth, or head ?_____Yes/No
Explain _____
Any unusual speech habits ?_____Yes/No
Explain _____

At what age did your child's first tooth come in?_____
Any lost teeth? _____ Yes/No
Explain _____
Orthodontic appliances worn now or previously?_____ Yes/No
Explain _____

How often are your child's teeth brushed?_____

Do you assist your child with tooth brushing (how often)? _____ Yes/No
Is dental floss used (how often)?_____ Yes/No
Is fluoride taken in any form?_____ Yes/No
Is your drinking water fluoridated?_____ Yes/No
Child's attitude toward dentistry (explain) _____
_____
_____
_____
_____

III. Medical History

Physician's Name_____
Physician's Telephone #_____
Has your child had a physical exam in last year? Yes/No
Is your child under care of physician now? Yes/No
Is your child current on their immunizations? Yes/No
General Health (please check) Excellent Good Fair Poor
Is your child taking any medication now (including Herbal or Complimentary medicines?) Yes/No
Name of Medication _____
For what purpose?_____
Prescribed by whom?_____

Has your child ever been hospitalized?_____ Yes/No
_____
Has your child ever had surgery?_____ Yes/No
Allergy to penicillin or other drugs (list)_____ Yes/No
_____
Other allergies: food – pollen – animals – dust – latex – other (list)__ Yes/No
_____
Does your child have good physical coordination (explain)?_____ Yes/No
_____
Are there behavioral or developmental issues (explain)?_____Yes/No
_____
How is your child doing in school?_____

HAS CHILD HAD ANY HISTORY OF (OR DIFFICULTY WITH) ANY OF THE FOLLOWING:

___ADD
___Anemia
___Arthritis
___Asthma (Pulmonary)
___Autism/ASD
___Bladder
___Bleeding Disorder
___ Cerebral Palsy
___ Chronic Sinus
___ Craniofacial
___ Developmental Delays
___ Diabetes
___ Ears
___ Emotional/Mental Health Issues
___Fainting
___Fever
___Gastrointestinal
___Hearing
___Heart
___Hepatitis
___Immunodeficiency
___ Jaundice
___ Kidney
___Liver
___ Malignancies
___ Measles/Mumps
___ Mental Retardation
___ Mononucleosis
___ Orthopedic
___ Premature Birth
___ Rheumatic Fever
___ Seizures
___ Thyroid
___ Tuberculosis
___ Other

I understand that the information I provide on this form is essential to determine my child's dental treatment. I understand that if any change occurs in my child's health I am to report it to the dental office as soon as possible.

_____
Please Initial & Date

GENERAL INFORMATION

Guardian #1 information: Relationship to patient _____

Full Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone # (____) _____-_____ Work Phone/Pager # (____) _____-_____
Cell Phone # (____) _____-_____ E-mail address _____
Date of Birth _____
Social Security # _____-_____-_____
Place of Employment _____
Employment Address _____
Dental Insurance Carrier _____ Group # _____
Insurance Mailing Address _____
Insurance Co. Telephone # (____) _____-_____ Policyholder name _____

What is parents' marital status? Single/Married/Divorced/Widowed/Remarried/Domestic Partners

Guardian #2 information: Relationship to patient _____

Full Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone # (_____) _____-_____ Work Phone/Pager # (____) _____-_____
Cell Phone # (_____) _____-_____ E-mail address _____
Date of Birth _____
Social Security # _____-_____-_____
Place of Employment _____
Employment Address _____
Dental Insurance Carrier _____ Group # _____
Insurance Mailing Address _____
Insurance Co. Telephone # (_____) _____-_____ Policyholder name_____

Person Financially Responsible _____
Relationship to Child _____
Address _____
City _____ State _____ Zip Code _____
Home # (_____) _____-_____ Work # (_____) _____-_____

Person to contact in case of emergency if you cannot be reached:
Name _____ Home # (____) _____-_____ Work # (____) _____-_____
Name _____ Home # (____) _____-_____ Work # (____) _____-_____

Whom may we thank for referring you to our office: _____

CONSENT:

Your child is a minor; therefore, it is necessary that a signed permission be obtained from a parent or guardian before any dental services can be started. I grant Indianapolis Pediatric Dentistry permission to provide my child with dental care and I will be responsible for the total cost of the dental care.

Signature _____ Date _____

FINANCIAL POLICIES

Please read the following carefully before signing.

Indianapolis Pediatric Dentistry is a participating provider with Delta Dental Premier, Anthem Dental Blue 100, 200 and 300, and Dental Health Options. We accept all insurances, however, we are not "in-network" with all insurances.

1. Payment is due in full at the time services are rendered. As a courtesy, we will gladly file your insurance when you are able to provide all pertinent information. You are responsible for prompt payment of any balances remaining after insurance claims have been processed. A monthly service fee plus interest will be charged on all accounts with an outstanding balance after 60 days.

2. We accept Personal Checks, MasterCard, Visa, Discover and Cash. A $30.00 fee will be assessed to your account for any check returned for non-sufficient funds.

3. The responsible party is the parent that brings the child in for the dental visit, independent of what a divorce degree may state. Reimbursement must be made between the divorced parties. We will not intervene.

4. You agree to be financially responsible for all charges related to the services provided in our office, as well as any interest fees, collection agency costs (including a $20.00 account collection forwarding fee), court costs and attorney fees for accounts that are not paid when due. Any accounts with balances that are 120 days past due may be forwarded to a third party collection agency.

Appointment Cancellation Policies

Every effort is made to see patients in a timely manner and according to schedule. On time arrival for appointments helps us to provide the quality experience for which we strive. If you arrive 15 minutes or more after your appointment time, you may be asked to reschedule or wait until there is an opening, depending upon schedule and staff availability.

In order to meet the demands of the busy schedules of our patients, we offer to place patients on a waiting list. Advance notice if you will need to reschedule your appointment is requested and appreciated so your appointment time can be offered to another patient.

Cancellation policy: Our office requires 48 hours notice of cancellation. For any appointment that is not cancelled 48 hours in advance, a fee of $50.00 per 30 minutes scheduled can be charged to your account. We reserve the right to dismiss a patient after the third failed appointment.

Signed_____ Date_____

(Parent or Guardian)