New Patient Registration

We welcome you to our practice! Please provide as much information as you can.
All information provided is confidential and will only be used for dental purposes.

Patient Info

First:_____ Middle:_____ Last:_____ Sex: ☐M ☐F

Preferred Name:_____ DOB:_____/_____/_____

Address:_____ Apt#:_____ City:_____ State:_____ Zip:_____

Biological Parent/Primary Legal Guardian

Relation:_____

Name:_____

Phone:(_____)_____ ☐Cell ☐Home

Alt Phone:(_____)_____ ☐Cell ☐Work

Email:_____

DOB:_____/_____/_____

Biological Parent/Secondary Legal Guardian

Relation:_____

Name:_____

Phone:(_____)_____ ☐Cell ☐Home

Alt Phone:(_____)_____ ☐Cell ☐Work

Email:_____

DOB:_____/_____/_____

Emergency Contact:_____ Phone:(_____)_____ Relation to Patient:_____

Referred by: ☐Dentist ☐Primary Care Dr. ☐Google ☐ Website ☐ Clinic ☐Insurance ☐Other:_____

Dental Insurance Subscriber/Policy Holder Info

Insurance:_____ ID/SSN:_____

Policy Holder Name:_____ Policy Holder DOB:_____/_____/_____

Ins Phone:(_____)_____ Group:_____ Relation to Pt:_____

Medical History

Child's Primary Physician:_____ Phone:(_____)_____

Location:_____ Address:_____

Is your child in good health? ☐Yes ☐No

Has your child ever had any health problems or been hospitalized for health reasons? ☐Yes ☐No

If yes, please describe:_____

Is your child now taking any prescriptions or over the counter medications? ☐Yes ☐No

If yes, please list:_____

Have you ever been told that your child needs to take antibiotics before treatment? ☐Yes ☐No

If yes, name of physician or dentist:_____ Phone:(_____)_____

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Consent for Services

I am the biological parent or legal guardian for the patient(s) and there are no court orders now in effect that limits me from signing this consent. I understand that the information I have given is correct to the best of my knowledge, that it will be held with confidentiality. It is my responsibility to inform the dental staff of any changes in my child(ren)s health status. I hereby authorize Dr. Travers and her staff to perform any necessary dental services including but not limited to comprehensive examination, taking dental x-rays, photographs or any diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs, cleanings, any recommended dental treatment mutually agreed upon and the use of appropriate medication, therapy and administration of anesthetic agent indicated for such treatment.

Initial_____

I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Travers and her staff will provide an environment that will help children learn to cooperate during treatment by using praise, explanation, demonstration of procedures and instruments, and using variable voice tones.

Initial_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

By signing below, you consent to the use and disclosure of your child's Protected Health Information (PHI) by Grace Children's Dentistry, it's staff and business associates for treatment, payment, and health care operations.

You have the right to request that we restrict our uses or disclosures of your child's Protected Health Information that we are otherwise permitted to make for treatment, payment, and healthcare operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding to us. You may refuse to consent to the use or disclosure of your child's PHI, but a written document is required. Under this law, we have the right to refuse services should you choose to refuse to disclose your child's Protected Health Information (PHI).

I acknowledge that I have read the above, that I am a biological parent or legal guardian of the patient(s), and that I have been informed and understand this Notice of Privacy Practices.

Biological Parent/Legal Guardian

Signature:_____ **Date:** _____/_____/_____

Print Name:_____ **Relation to Patient(s):**_____

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Allergies

Has your child ever had any allergic reaction to: ☐Food ☐Medication ☐Latex ☐Metal ☐Other:_____

Medical Conditions

Please indicate if your child has any of the following:

General Conditions			Behavior/Learning Conditions		
Asthma	☐Yes	☐No	ADHD	☐Yes	☐No
Diabetes	☐Yes	☐No	Anxiety/Nervousness	☐Yes	☐No
GI Disorder	☐Yes	☐No	Autism	☐Yes	☐No
Heart Disease or Murmur	☐Yes	☐No	Emotional Disability	☐Yes	☐No
Kidney Disease	☐Yes	☐No	Learning Disability	☐Yes	☐No
Liver Disease	☐Yes	☐No	Behavior Issues	☐Yes	☐No
Rheumatic Fever	☐Yes	☐No	Psychiatric Disorder	☐Yes	☐No
Developmental Delay Conditions					
Brain Injury	☐Yes	☐No	Growth Problems	☐Yes	☐No
Cerebral Palsy	☐Yes	☐No	Fainting	☐Yes	☐No
Cleft Lip/Palate	☐Yes	☐No	Speech Problems	☐Yes	☐No
Developmental Delay	☐Yes	☐No	Hearing Loss	☐Yes	☐No
Orthopedic Problems	☐Yes	☐No	Neuromuscular Defect	☐Yes	☐No
Infectious Conditions			**Blood Related Conditions**		
Hepatitis	☐Yes	☐No	Anemia	☐Yes	☐No
HIV / AIDS	☐Yes	☐No	Bleeding (Abnormal)	☐Yes	☐No
Tuberculosis	☐Yes	☐No	Hemophilia	☐Yes	☐No
Other Conditions					
Cancer	☐Yes	☐No	Severe Headaches/Migraines	☐Yes	☐No
Epilepsy/Seizures	☐Yes	☐No	Gag Reflex	☐Yes	☐No
Leukemia	☐Yes	☐No	Sleep Apnea	☐Yes	☐No
Down Syndrome	☐Yes	☐No	Sleep Disorder	☐Yes	☐No
Tourette Syndrome	☐Yes	☐No	Excessive Snoring	☐Yes	☐No

Does your child have any disease, condition, or problem **not listed above** that you think we should know about?

If yes, please explain:_____

Dental History

Is this your child's first visit to the dentist? ☐Yes ☐No

If no, when was the last visit?_____Previous Dentist:_____

Phone:(_____)_____Office Location:_____

Please check any of the following that may describe your child's attitude towards dentistry:

☐Friendly ☐Cooperative ☐Anxious ☐Shy ☐Uncooperative ☐Unfriendly

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Dental History (continued)

Has your child ever had an unhappy dental experience? ☐Yes ☐No
Has your child ever had local anesthetic (Novocain)? ☐Yes ☐No

If yes, were there any problems?_____

Please check if your child has any of the following:

Cavities	☐Yes ☐No	Sensitive Teeth	☐Yes ☐No
Gum Infection	☐Yes ☐No	Discolored Teeth	☐Yes ☐No
Toothache	☐Yes ☐No	Trauma	☐Yes ☐No
Crowding/Spacing of Teeth	☐Yes ☐No	Other:_____	

Is there anything else that you would like to tell us regarding your child's dental health?_____

_____

Habits

Does your child brush his/her teeth daily? ☐Yes ☐No Do they floss? ☐Yes ☐No
Do you assist in brushing your child's teeth? ☐Yes ☐No
Does your child take fluoride in any form? ☐Tablets ☐Drops ☐Water ☐Paste/Gel ☐Rinse

Does your child have any of the following habits?

Nursing Bottle	☐Yes ☐No	Pacifier Sucking	☐Yes ☐No
Nail Biting	☐Yes ☐No	Grinding Teeth	☐Yes ☐No
Thumb/Finger Sucking	☐Yes ☐No	Cheek/Lip Biting	☐Yes ☐No
Mouth Breathing	☐Yes ☐No	Clenching Jaw	☐Yes ☐No

How often does your child have sugar snacks? (Candies, gum, etc.) per day_____/per week_____

How many cups of soda or juice does your child drink? per day_____/per week_____

Biological Parent/Legal Guardian

Signature:_____ **Date:**_____/_____/_____

Print Name:_____ **Relation to Patient:**_____

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Appointment Policy

Our office shares the same priorities for your child's well-being. We make the effort to schedule appointments for the best interest of your child. Dental appointments are justified absences. Missing days of school can be minimized when regular dental care is continued.

Late Policy

Please keep in mind, for a typical 30-minute appointment, being late even 10 minutes may decrease the time and quality of care your child should receive. Please keep in mind that if you arrive more than 10 minutes late, the appointment may be rescheduled to another day that we can give you enough time for your visit.

Appointments for Siblings

We understand that your time is very valuable. We can make appointments for up to 2 siblings from the same family to come together for their regular checkup appointments. Please keep in mind that we set aside 1 hour for your family. If you miss this type of appointment, any schedule in the future will be for 2 children only. The same policy applies to all siblings.

Broken Appointments

As scheduled appointments are reserved exclusively for each patient, we ask that you please notify our office at least 48 hours in advance if you are unable to meet your appointment. If your child is scheduled for dental treatment, especially if sedation or general anesthesia is used, our office requires 48 hours' notice if you are unable to meet your appointment. We understand that unexpected things happen, but we ask for your help in these instances.

Our broken Appointment Policy fees are as follows:

First broken appointment: $25 failed appointment fee

Second broken appointment: $50 Failed Appointment Fee per patient and/or dismissal from the practice

This is NOT in any way an attempt to punish a patient for unexpected emergencies (sudden illness, accidents). The rates listed above do not apply to these unforeseen circumstances, they apply if they are an ongoing problem. If an appointment cannot be met, please call us at least 48 hours before your appointment to cancel.

We strive to provide the best quality of care for your child. We appreciate your cooperation and understanding.

I have read and understand the appointment policies mentioned above and agree to abide by the fee structure as per necessary.

Signature:_____ **Date:** _____/_____/_____

Print Name:_____ **Relation to Patient(s):**_____