Patient Registration

Today's Date _____ Date of Birth _____

Patient's Name

_____

Nick Name _____

Male _____ Female _____

Address

_____

_____

Home Phone # _____

Mother's First/Middle/Last Name

_____

Date of Birth _____ Social # _____

Driver License # _____

Employer _____

Contact # _____

E-Mail _____

Father's First/Middle/Last Name

_____

Date of Birth _____ Social # _____

Driver License # _____

Employer _____

Contact # _____

E-Mail _____

With whom does patient live?

_____

Person Responsible for Account

Name

_____

Relationship_____ Contact#_____

Billing Address

_____

_____

Primary Dental Insurance / Dental Coverage

Insurance Co. Name_____

Insurance Co. Address

_____

_____

Insurance Co. contact #_____

Name of Policy Holder _____

Relationship to Pt _____ Date of Birth _____

Group(Plan or Policy)# _____

Policy Holder's Employer _____

Secondary Dental Insurance / Dental Coverage

Insurance Co. Name_____

Insurance Co. Address

_____

_____

Insurance Co. contact #_____

Name of Policy Holder _____

Relationship to Pt _____ Date of Birth _____

Group(Plan or Policy)# _____

Policy Holder's Employer _____

Patient's Name _____ DOB _____ Today is _____

Patient Dental History

Please answer the following questions:

Has your child been to any dental office in the last six months? Yes/No

If yes, what was the dentist's name? _____

If yes, when was the visit and what was done? _____

Has your child ever had dental X-rays? Yes/No If yes, when? _____

Has your child ever had problems with dental anesthetics? Yes/No If yes, explain: _____

Do you expect your child to be a cooperative dental patient? Yes/No If no, explain: _____

Please rate your child's comfort level with receiving dental treatment: Comments: _____

( ) Unknown ( ) No Problem ( ) Slightly Anxious ( ) Moderately Anxious ( ) Fearful

REASON FOR VISIT

( ) Routine Visit ( ) Cosmetic ( ) Habit ( ) Orthodontic ( ) Behavior ( ) Education ( ) Decay ( ) Physical/Mental Handicap

( ) Emergency ( ) Other: _____

Does your child have or has had any of the following?

- Thumb sucking Yes/No How Long? _____ Still active? Yes/No
- Finger Habit Yes/No How Long? _____ Still active? Yes/No
- Pacifier Yes/No How Long? _____ Still active? Yes/No
- Dental Trauma Explain: _____

Does your child clench or grind their teeth? Yes/No If yes, explain: _____

Does your child sleep with a bottle at night? Yes/No If yes, explain: _____

Does your child's bottle or sippy cup contain fluid other than milk or water? Yes/No If yes, explain: _____

Does your child use fluoride toothpaste? Yes/No If no, explain: _____

PREVENTATIVE

How often does your child brush? _____ Does your child floss their teeth? Yes/No

Is tooth brushing and flossing supervised? Yes/No By whom? _____

Does your child drink: ( ) Fluoridated water- city or county ( ) Bottled water ( ) Filtered Water ( ) Well water

Does your child take: ( ) Fluoride in vitamins ( ) Fluoride in tablets/drops Other: _____

Patient's name: _____ DOB _____ Today is _____

Medical History

Is your child presently under the care of a ( ) Pediatrician or ( ) Family Physician

For specific medical reason? Yes/No If yes, explain: _____

Physician's name _____ Contact # _____

Date of last medical exam _____

Is your child in good health? Yes/No If no, explain: _____

Is your child taking any medications at this time? Yes/No If yes, list _____

Has your child ever been hospitalized? Yes / No

If yes, when and for what reason? _____

a. Does your child have any of these conditions? ( ) Heart Murmur ( ) Pins ( ) Plates ( ) None
b. If so, has your child been instructed to be pre-medicated for this or other condition? Yes / No

Is your child up to date with immunizations? Yes/No

Is your child allergic to any medication? Yes/No If yes, explain: _____

Does your child have any allergies? Yes/No

Have you ever been told that your child needs premedication

for a heart condition before dental treatment? Yes/No If yes, explain: _____

Has your child's tonsils and/or adenoids been removed? Yes/No If yes, explain: _____

CHECK ANY OF THE FOLLOWING THAT MAY PERTAIN TO YOUR CHILD:

____ Anemia	____ Cleft Lip / Palate	____ Hearing Loss	____ Cognitive Delay
____ Attention Deficit disorder	____ Convulsion / Seizures	____ Heart Disease	____ Nutritional Deficiency
____ Allergy	____ Diabetes	____ Hemophilia	____ Orthopedic Problem
____ Autism	____ Emotional Disturbance	____ Hepatitis-Type_____	____ Rheumatic Fever
____ Asthma	____ Epilepsy	____ Heart Murmur	____ Sickel Cell Anemia
____ Brain Injury	____ Eye Problems	____ Hyperactivity	____ Spina Bifida
____ Cancer	____ Excessive Bleeding Problem	____ Jaundice	____ Syndrome
____ Cerebral Palsey	____ Fainting	____ Leukemia	Other _____

_____ None of the above

Explain any items checked above:

_____

X_____ _____ _____

Signature of person completing form | Relationship to Patient | Date

Lucky Kids Dental, PC

Acknowledgement

I, _____ , hereby acknowledge that I have received and reviewed a copy of Lucky Kids Dental, PC's HIPAA Notice of Privacy Practices. I understand that Lucky Kids Dental, PC's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Lucky Kids Dental, PC's revised HIPAA Notice of Privacy Practices upon request. I understand that if I have any questions about Lucky Kids Dental, PC's HIPAA Notice of Privacy Practices, I may contact Lucky Kids Dental at (972)758-8777. I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Lucky Kids Dental, PC will not refuse treatment to me if I refuse to sign this Acknowledgement. I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Lucky Kids Dental, PC's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Nicole McKnight, noted above, for assistance.

_____ _____

Patient Signature Date

_____ _____

Signature of Personal Representative Relationship to Patient

This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, _____ authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____

{Please Print Name} Relationship

_____

{Please Print Name} Relationship

May we contact you by phone and leave a message?

Primary Phone#: _____

( ) Leave message with detailed information

( ) Leave message with contact number only

( ) Do not leave message

Secondary Phone#: _____

( ) Leave message with detailed information

( ) Leave message with contact number only

( ) Do not leave message

FOR OFFICE USE ONLY

Lucky kids Dental, PC made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its HIPAA Notice of Privacy Practices. In spite of these efforts, Lucky Kids Dental, PC was unable to obtain a signed Acknowledgement for the following reason(s):

( ) Refusal to sign Acknowledgement on _____, 20_____ .

( ) Communications barriers prohibited us from obtaining a signed Acknowledgement.

( ) An emergency situation prohibited us from obtaining a signed Acknowledgement.

( ) Other : _____

Date Received : _____ By : _____ Patient Name _____

Dental Treatment consent

- I hereby authorize the dentist, assistants or dental hygienists to take x-rays, impressions, study models, and other diagnostic aids deemed appropriate by the dentist to make a diagnosis of your child (name of patient) _____ dental needs.

- I authorize the dentist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

- I consent to the administration of anesthetics and other medications as may be considered necessary and advisable by the dentist. I understand that there are risks and benefits that may occur and are possible in the performance of any procedure. I can ask for an explanation of possible risks and benefits.

- I give consent to the dentist's or designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations.

- I understand that students in dental care professions may be present or participate in my care under supervision. I also understand, that in the event there is a need for technical support concerning dental equipment or dental supplies, representatives required for that purpose may need to be present in the operatory or procedure room. I consent to their presence.

- I acknowledge that I am responsible and I hereby agree to pay for the services provided to me or my dependents by Lucky Kids Dental, PC. I understand that payment or co-payment is due at the time of services, unless other arrangements have been made.

This consent is effective for 12 months from the date of signature below.

_____ _____/_____/_____

Patient signature (Person authorized to consent for patient) Date (month/day/year)

_____ _____/_____/_____

Witness Date (month/day/year)

Cancellation Policy

If you need to cancel your appointment, kindly **give our office at least a 48 hour notice**. We have changed our policy for missed appointments and want you to be aware of this policy.

Cancellation Policy:

- **1st Cancellation** – Someone from our office will notify you of your missed appointment to determine if there were any extenuating circumstances.
- **2nd Cancellation – A Fee of $ 25** will be charged to you. **It will not** be billed to your insurance.
- **3rd Cancellation** – At this time, the patient will be dismissed from the practice.

Saturday Cancellation Policy:

A fee of $50 will be charged to you for not giving a 48 hour notice or no show.
In addition, **this cancellation/no show will result in forfeiting any future Saturday appointments.**

It is unfortunate that we must adhere to this policy. It is very important to the care of our patients to keep your scheduled appointment with your provider. When patients don't give at least a 48 hour notice before cancelling an appointment, it prevents other patients from being scheduled in these appointment slots.

Thank You,

Lucky Kids Dental, PC

Sign _____ Date _____

About dental insurance and financial responsibility

Thank you for choosing our office for your child's dental needs. We do our absolute best to help you understand and estimate your insurance benefits. As a courtesy, our office will verify your insurance with your insurance carrier as long as you provide us with your up-to-date and correct insurance information **no less than 1 business day** before your child's appointment. In addition, we will file your child's dental claim with your insurance carrier. Keep in mind all insurance companies include a disclaimer stating verification does not guarantee payment. Due to the **thousands of insurance plans** we ask that you **know your benefits** for it would **be impossible for us to know them all**. Each insurance plan is unique in what services they will allow. Please be aware that your dental insurance plan is a contract between you, your employer, and the insurance company. It is your responsibility to know the benefits, limitations and exclusions of your dental plan. If you are unhappy with its specific coverage, please contact your Human Resources Department.

Only your employer can adjust benefits or change policies. We are not responsible, nor can we guarantee, how your insurance carrier will pay on a claim. Once the insurance carrier has paid their portion, the remaining balance will become your responsibility.

Please note that treatment plans change on occasion during the course of treatment because conditions can worsen or improve and can therefore change your financial responsibility in either direction.

Your deductible and/or copay is due at the time services are rendered. Because your insurance company makes no guarantee of payment, we cannot always guarantee your exact insurance coverage. Therefore, you may receive a statement with an additional balance after your insurance has met their obligation. We ask that your portion be paid at the time of service or within 15 days of receiving such statement. We are always available to answer your questions and/or assist you in any way we can.

I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office and that it is **my responsibility to notify the office of any changes in my insurance**.

Signature **Relationship to child** **Date**

Authorization for Non-Parent/Guardian Consent

Our office encourages that all parents or legal guardians accompany their child to each dental appointment. If the parent is unable to accompany the child for their initial dental appointment or recall visits please fill out this form. This consent however, does not extend for dental treatment under IV/Oral Conscious Sedation or general anesthesia. If we are unable to obtain consent and/or information needed, we will reschedule your child's appointment.

Child(ren) name(s):

_____

_____

Authorized caregiver's name

Relationship to child(ren)

_____ _____

Caregiver's phone number

_____

I give permission for the above name caregiver shall be authorized to accompany the above named child(ren) for their initial examinations and subsequent recall visits. Treatment to be performed include routine pediatric dental services (examinations, cleanings, radiographs, fluoride treatment, and restorative needs as have been already fully explained to me). The initial patient registration package, all medical history/dental history must be filled out by parent or legal guardian.

This consent shall be effective from date of signature until revoked by parent or legal guardian.

I can be reached at _____

Phone number

Signature of Parent/Guardian, Date

Printed Name of Parent/Guardian

_____ _____