PIMA PEDIATRIC DENTISTRY - *REGISTRATION*

BACKGROUND INFORMATION

TODAY'S DATE: _____
Patient's name: _____ Nicknames: _____
Child's Date of Birth: _____ Age: _____ Male: _____ Female: _____
Address: _____ City _____ State ____ Zip _____
Home phone: (child's) _____ Parent: _____
School Attending: _____ Grade: _____
Child's Hobbies: _____
Siblings (with age): _____
_____
Are siblings patients of Pima Pediatric Dentistry? ____ Yes ____ No
Whom may we thank for referring you to our practice? _____

PARENT/GUARDIAN INFORMATION

A. Parent/Guardian: _____ Date of Birth:_____ SSN:_____
How do you wish to be addressed? _____
Marital Status: __-Single __-Married __-Divorced __-Widow __-Widower
Your address(if different from child's): _____ City _____ State ____ Zip _____
Telephone: Residence _____Business _____*Cell Phone:*_____
How may we contact you? ___-Home Phone ___-Business Phone ___-Cell Phone
Employer and Address: _____How long _____
E-mail address: _____
B. Spouse/Other Responsible Party _____ Date of Birth:_____ SSN:_____
Marital Status: __-Single __-Married __-Divorced __-Widow __-Widower
Your address(if different from child's): _____ City _____ State ____ Zip _____
Telephone: Residence _____Business _____*Cell Phone:*_____
How may we contact you? ___-Home Phone ___-Business Phone ___-Cell Phone
Employer and Address: _____How long _____
E-mail address: _____

EMERGENCY INFORMATION

In case of an emergency, besides yourself, whom should we notify? _____
Relationship _____ Telephone _____

RESPONSIBLE PARTY INFORMATION

Who is responsible for this account? _____
Social Security # _____ Drivers license No. _____

DOES YOUR CHILD HAVE DENTAL INSURANCE?

PRIMARY COVERAGE:
Name of Insurance Co.: _____Telephone of Insurance Co.: _____
Address of Insurance Co.: _____
Subscriber name: _____ Date of birth: _____ SS#: _____
Employer: _____ Member or Policy #: _____ Group #: _____

CONSENT AND RELEASE

I authorize Pima Pediatric Dentistry (Sophie L. Baird, D.D.S.) to perform those diagnostic procedures and treatment as may be necessary for proper dental care. I authorize release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to Pima Pediatric Dentistry, otherwise payable to me. I understand that my dental care insurance carrier or the payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts and, if my insurance carrier does not pay the claim within 45 days, the entire claim becomes my responsibility. I authorize the release of any medical or dental information necessary to process all claims and I authorize Pima Pediatric Dentistry to communicate with pharmacists and physicians as necessary by letter, phone or fax. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor. I attest to the accuracy of information contained within this Registration Form.

Parent/Guardian signature _____Date _____

CHILD'S HEALTH HISTORY

DENTAL HISTORY- PLEASE ANSWER ALL QUESTIONS FULLY

What is the reason for your child's visit today? _____
Date of last dental visit: _____ Last dental cleaning: _____
What was done at the last dental visit? _____
Previous dentist's name: _____
Address _____ City/State _____ Telephone: _____
How many times daily does your child brush his/her teeth? _____

Does your child floss his/her teeth daily?	___ Yes	___ No
Do you help your child brush/floss his or her teeth?	___ Yes	___ No
Does your child eat between meals?	___ Yes	___ No
Does your child eat sweets such as candy, soda pop or chewing gum?	___ Yes	___ No
Does your child receive fluoride?	___ Yes	___ No

If yes – describe? _____
Have any cavities been noted in the past? ___ Yes ___ No
If so, were they treated? ___ Yes ___ No
Has your child sustained any injuries to the face, mouth or teeth? ___ Yes ___ No
If yes, please describe _____
Has your child had any problem with dental treatment in the past? ___ Yes ___ No
If yes, please describe _____
Has anyone on the family, including parents, had orthodontics? ___ Yes ___ No
Has your child ever received a local anesthetic – Novocain/Lidocaine? ___ Yes ___ No
If yes, how was your child's experience _____
Has your child ever had occlusal sealants? ___ Yes ___ No
Do you or your child think there is anything wrong with his/her teeth? ___ Yes ___ No
If yes, please describe_____

PATIENT NAME:_____DOB:_____
DATE OF SERVICE:_____ INS.:_____

MEDICAL HISTORY- PLEASE ANSWER ALL QUESTIONS FULLY

Who is your child's physician? _____ Phone _____
Has child been under the care of a medical doctor during the past two years? _____ Yes _____No
If yes, when and why? _____
Name of physician? _____ Phone _____
Address _____ City/State _____ Zip _____
Has your child taken any medication or drugs during the past two years? ___ Yes ___No
If yes, please list name and dosage _____
Is your child currently taking any medications? ____ Yes ____ No
If yes, what medications and for what condition(s) _____
Are you or your child **allergic** to any medication or substance? ___ Yes ___No
If yes, please list _____
Are you or your child **allergic** or sensitive to latex or any metals? ___ Yes ___No
If yes, please list _____
Indicate which of the following your child has or had. Please check "yes" or "no"

Yes	No		Yes	No		Yes	No	
[ ]	[ ]	Heart problems	[ ]	[ ]	High blood pressure	[ ]	[ ]	Low blood pressure
[ ]	[ ]	Heart valves	[ ]	[ ]	Valley fever	[ ]	[ ]	Rheumatic fever
[ ]	[ ]	Heart Murmur	[ ]	[ ]	Artificial joints	[ ]	[ ]	Epilepsy
[ ]	[ ]	Asthma	[ ]	[ ]	Seizures	[ ]	[ ]	Emotional problems
[ ]	[ ]	Tuberculosis	[ ]	[ ]	Frequent colds	[ ]	[ ]	Ulcers
[ ]	[ ]	Liver disease	[ ]	[ ]	Diabetes	[ ]	[ ]	Endocrine problems
[ ]	[ ]	Hyperthyroidism	[ ]	[ ]	Hypothyroidism	[ ]	[ ]	Anemia
[ ]	[ ]	Hemophilia	[ ]	[ ]	Sickle cell anemia	[ ]	[ ]	Excessive bleeding
[ ]	[ ]	Bruise easily	[ ]	[ ]	HIV/AIDS	[ ]	[ ]	Blood transfusion
[ ]	[ ]	Hepatitis A/B/C	[ ]	[ ]	Cancer	[ ]	[ ]	Tumors
[ ]	[ ]	Radiation therapy	[ ]	[ ]	Drug/chemotherapy	[ ]	[ ]	Kidney problems
[ ]	[ ]	STD's	[ ]	[ ]	Arthritis	[ ]	[ ]	Vision problems
[ ]	[ ]	Behavioral problems	[ ]	[ ]	Mononucleosis	[ ]	[ ]	Persistent nose bleeds
[ ]	[ ]	Fainting spells	[ ]	[ ]	Dizziness	[ ]	[ ]	Ringing in ears
[ ]	[ ]	Bladder problems	[ ]	[ ]	Headaches	[ ]	[ ]	Infective Endocarditis

Has your child ever been hospitalized: ___ Yes ___No
If yes, why? _____
Is there anything else about you or your child's health history that we should know? ____ Yes ____ No
If yes, please describe _____
_____
Is your child current with his/her immunizations? ____ Yes ____ No
If no, why not? _____

Teenage females: Are you pregnant? ___ Yes ____ No If so, how many months? ____
Nursing? ____Yes ____ No
Taking birth control pills? ____ Yes ____ No

PATIENT NAME:_____DOB:_____
DATE OF SERVICE:_____ INS.:_____

HERBAL MEDICATIONS AND OVER-THE COUNTER DRUGS

Many people use herbal medications and over-the-counter remedies daily. Several of these medications/remedies interact with medications used in dentistry. Please note – we cannot list every herb, vitamin supplement, dietary supplement or over-the-counter medications that exist as such a list would be enormous. For example, there are over 166 herbs presently recommended for various matters.

IS YOUR CHILD PRESENTLY USING OR WERE THEY PREVIOUSLY USING ANY OF THE FOLLOWING:

A. Dietary Supplements: Yes _____ No _____
Name of Supplement(s): _____
Reason for taking the Supplement(s): _____
Who instructed you to give your child the Supplement(s): _____

B. Herbal Medications: Yes _____ No _____
Name of Herbal Medication(s): _____
Reason for taking the Herbal Medication (s): _____
Who instructed you to give your child the Herbal Medications(s): _____

C. Vitamin Supplements: Yes _____ No _____
Name of Vitamin Supplement(s): _____
Reason for taking Vitamin Supplement(s): _____
Who instructed you to give your child the Vitamin Supplement(s): _____
_____

D. Over-the-Counter Medications: Yes _____ No _____
Name of Over-the-Counter Medication(s): _____
Reason for taking Over-the-Counter Medication(s): _____
Who instructed you to give your child the Over-the-Counter Medication (s): _____

E. Is your child taking any other medications, supplements or other things: Yes _____ No _____
Name: _____
Why: _____

VERIFICATION OF INFORMATION

I understand the above information found above (pages 1 -4) is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions correctly and fully and to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. I will promptly notify you of any change in my child's health or use of medications.

Parent/Guardian Signature: _____ Date:_____

PIMA PEDIATRIC DENTISTRY FINANCIAL POLICY

Thank you for choosing Pima Pediatric Dentistry as your child's oral health care provider. We would like to assure you that we will do our best to provide your child with the highest quality pediatric dental care possible in a caring, compassionate child-friendly atmosphere. In order to eliminate any confusion, the following represents the financial policies followed by Pima Pediatric Dentistry. Please read this Financial Policy carefully. Please understand that this Financial Policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases. Should you have any questions, please ask. Having open lines of communication allows us to concentrate on what we do best…*provide quality dental care for your child.*

PATIENTS WITH VERIFIABLE INSURANCE COVERAGE

We see patients by appointment only. All patients utilizing insurance coverage are required to bring their current insurance cards with them to each appointment. Additionally, please have a driver's license or photo ID. Insurance coverage is a contract between you, the patient (or parent) and the insurance company. The terms of that contract determine the amount of coverage (benefit) you have for any procedure or visit. As a courtesy to you, we will be glad to assist you in obtaining the appropriate benefit from your insurance carrier by completing your insurance forms and mailing (or electronically filing) it to your insurance provider. We must have accurate and up-to-date insurance information in order to bill your insurance company. We require that you pay any deductibles and co-payments at the time of service. We also require that you pay the estimated portion of your treatment (that portion the insurance carrier is not expected to pay) prior to, or at each visit. As treatment is completed, we will bill your insurance carrier for the services rendered. In the event your insurance carrier has not paid their portion within forty-five (45) days, the full balance becomes your responsibility.

Should you request in writing that we do so, we will request a pre-estimate of benefits from your insurance carrier. Routine treatment is generally performed without submitting a request for pre-estimate of benefits.

Certain patients have double coverage (this is possible if more than one party has dental insurance) - we will only bill the primary carrier for services rendered. However, as a courtesy to you, we will submit to the secondary carrier after your account has been paid in full.

PATIENTS WITHOUT INSURANCE COVERAGE OR WITH INSURANCE WE DO NOT ACCEPT

Please contact your insurance carrier to verify whether or not Pima Pediatric Dentistry participates with your insurance plan. Patients without insurance coverage or with insurance coverage we do not accept are expected to pay in full for services as they are rendered. We accept many major credit cards as well as personal checks and cash. We generally do not extend credit to patients/parents, instead we ask that you use the services of an outside financing company such as CareCredit.

Missed appointments: Please be aware that there is a cost to Pima Pediatric Dentistry for no shows or missed appointments. Appointments canceled with less than 48 hours' notice are subject to a $50.00 cancellation charge and future appointments will be subject to our **Same Day Appointment Policy**. For **Same Day Appointments**, call us on a day that you can bring your child to the office, and if time allows, we will work your child into the schedule. Please help us serve you more efficiently by keeping your scheduled appointments. We reserve the right to dismiss your child from the practice if you miss appointments or cancel them with less than 48 hours' notice.

Returned Checks: Checks returned by the bank due to insufficient funds are subject to a $35.00 processing charge per check returned. No further appointments will be scheduled unless payment is received in full prior to such appointments. Such payment must be by certified check or cash.

Finance Charges: Accounts unpaid after 45 days from the date of service are subject to a finance charge at the rate of 1.5% per month (18% per year).

Unpaid Accounts: Accounts 90 or more days past due may be sent to a collection agency and will be assessed a $50.00 collection fee. In addition, you will be responsible for all costs of collection, including court costs, attorneys' fees, and interest charges.

I, the undersigned, assume financial responsibility as stated above and agree to be responsible for all collection and legal fees if my account becomes past due. I HAVE READ, UNDERSTAND, AND AGREE TO THE FINANCIAL POLICY OF Pima Pediatric Dentistry.

Patient(s) Name: _____

Parent/Guardian Signature: _____ Date:_____

CONFIDENTIALITY STATEMENT:

This office follows all rules and regulations regarding confidentiality of patient dental/medical records. Employees of Pima Pediatric Dentistry have access only to patient information necessary to properly carry out the functions of their jobs. Only information necessary to process claims is released to insurance companies.

PIMA PEDIATRIC DENTISTRY
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of Pima Pediatric Dentistry's Notice of Privacy Practices.

_____
Print Child's Name

_____
{Your Signature}

_____
{Date}

Please list those, other than yourself, that are authorized to bring your child to dental appointments or

are able to request dental information over the phone:_____.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____