MeadowsFamilyDentistry

pediatric • orthodontic • adult care

Smiles for Life

Child Registration

Child's Name: _____ Nickname: _____ Male_____ Female_____

Child's Birth date _____/_____/_____Age_____Home # (_____) _____School: _____

Child's Home Address: _____Apt/Unit #_____

City: _____State: _____Zip_____

Previous Dentist: _____Last Visit Date: _____

Who Is Accompanying The Child Today?

Name: _____Relation: _____

Do you have legal custody of this child? Yes_____No_____

Whom may we thank for referring You? _____

Other family members seen by us: _____

_____

Parent's Marital Status: Married_____Single_____Divorced_____Separated_____Widowed _____

Who is responsible for making appointments? _____

How would you like to receive appointment reminders? Text _____Email _____Both _____

Mother's Information

Stepmother ___Guardian ____

Name: _____

Address: _____

City: _____State: _____Zip: _____

Birth date: _____/_____/_____SS#

Cell phone # (_____) _____

Work # (_____) _____

Employer: _____

Driver's License #_____

EMAIL: _____

Father's Information

Stepfather ___Guardian__

Name: _____

Address: _____

City: _____State: _____Zip: _____

Birth date: _____/_____/_____SS# ---------- _____

Cell phone # (_____) _____

Work # (_____) _____

Employer: _____

Driver's License #_____

EMAIL: _____

Dental History

Why did you bring the child to the dentist today? _____

Has the child ever had a serious/difficult time associated with previous dental work? Yes _____No

Has the child ever had pain/tenderness in the jaw joint (TMJ/TMD)? Yes _____No____

Does the child brush his/her teeth daily? Yes_____No_____Floss his/her teeth daily? Yes _____No____

Consent for Treatment

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidences and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Parent's signature: _____ Date: _____

Has the child ever had any of the following medical problems?

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N Autism/Sensory Issues
Y N Operations/Hospital Stays
Y N Artificial Bones/Joints
Y N Asthma
Y N Cancer
Y N Heart Defects/Disease
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities _____
Y N Hearing/Speech Impairment
Y N Heart Murmur
Y N Anything Require a Pre-med?
Y N Hemophilia
Y N Hepatitis
Y N HIV+/AIDS
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Sickle Cell Disease/Traits
Y N Tuberculosis (TB)

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Does your child have any of the following habits?

Y N Lip Sucking/ Biting

Y N Nail Biting

Y N Nursing Bottle Habits

Y N Thumb/Finger Sucking

Is the child currently under the care of physician? Yes_____No_____

Please discuss any serious medical problems that the child has had: _____

_____

_____

Please list any medications the child takes: _____

_____

Does the child have any medication allergies? _____Yes _____No If yes, please list: _____

_____

Name of Child's physician: _____Phone number: _____

Our Financial Policy

Patients WITH Insurance Coverage: Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you maximize the benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments of your account. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due **prior to the treatment**. If your insurance company has not paid the claim within 45 days, the balance will be automatically transferred to you. In some cases, the insurance carrier may pay for alternative benefits other than the treatment performed. In this case, you are responsible for paying for the difference. Even if you have dual coverage (which is possible when you and your spouse both have insurance) there may still be a portion that is your responsibility.

Patients WITHOUT Insurance Coverage: Patients without insurance coverage are required to pay for services as rendered. We accept Cash or Check, all major Credit/Debit cards, and CareCredit.

Scheduling Appointments: Because instruments, chairs and personnel are reserved exclusively for your appointment, we reserve the right to charge a **$35 fee for all appointments canceled less than 24 hours in advance.**

It is our office policy that the parent/guardian who requests treatment for the child is responsible for all services and fees.

I have read and understand the Meadows Family Dentistry financial policy.

Signature_____Date_____

Insurance Information

Do you have Dental Insurance? ____Yes ____No

Insurance Company: _____Insured's Name: _____

Employer: _____Group Number:_____

Subscriber ID #:_____Subscriber's Date of Birth_____/_____/_____

I hereby authorize Meadows Family Dentistry to provide any necessary information to the insurance carriers concerning treatment and to accept any payments made directly to them by my insurance carrier.

Signature: _____Print Name: _____ Date: _____

Please advise us if there is secondary dental insurance coverage

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HIPAA Disclosure and Release of Information

I, _____, hereby authorize Meadows Family Dentistry, LLC (hereafter collectively referred to as the "Practice") to use and disclose the entire medical record concerning _____ in accordance with the attached Notice of Privacy Practices (NOPP). I have received and reviewed a copy of the NOPP, been given an opportunity to ask questions about it, understand it and do here by agree to its terms. A copy of this signed, dated Consent shall be effective as the original. I release, hold harmless and agree to indemnify Practice, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

_____ _____ _____

Patient Name | Signature of patient or parent/guardian | Date

Consent for Communication and/or Disclosure

I request the following alternative or limitations relating to communication directed to me by my healthcare provider or employee of Meadows Family Dentistry, LLC. I understand that this HIPAA consent applies to ALL providers of Meadows Family Dentistry. It is my responsibility to notify Meadows Family Dentistry of any changes.

Do we have permission to:

Send appointment reminders via (please check the following): TEXT ☐ EMAIL ☐ BOTH ☐

Leave the following information on your home/cell voicemail?

Appointment Information ___Yes___No

Billing Information ___Yes ___No

Medical Information ___Yes ___No

I give my permission to share the following information with the person(s) listed below:

Name: _____ Relationship: _____

Appointment: ___Yes ___No Billing: ___Yes ___No Medical: ___Yes ___No

Name: _____ Relationship: _____

Appointment: ___Yes ___No Billing: ___Yes ___No Medical :___Yes ___No

_____ _____ _____

Patient Name | Signature of patient or parent/guardian | Date