NORTH SUBURBAN
DENTAL

CHILD REGISTRATION FORM

PATIENT INFORMATION

Date ____________________

Child Name ____________________ (LAST, FIRST, M.I.) Nickname ____________________

Date of Birth ____________________ Gender ❒ Male ❒ Female

Address ____________________ Zip ________ Home Phone ____________________

Emergency Contact ____________________ Emergency Phone ____________________

Are the parents or siblings North Suburban Dental patients? ❒ No ❒ Yes ____________________ (NAME(S))

Child lives with ❒ Parents ❒ Mother ❒ Father ❒ Grandparent ❒ Other ____________________

How did you hear about our office?

- ❒ Friend/Relative
- ❒ Mailing
- ❒ Social Media Site ____________________
- ❒ Computer Search
- ❒ Dental Insurance
- ❒ Current North Suburban Dental Patient

Who may we thank for referring you? ____________________

PARENT AND INSURANCE INFORMATION

Please provide front desk with a copy of your insurance card.

Person Responsible for Account ____________________ Relationship to Patient ____________________

Person Responsible for Making Appointments ____________________ Preferred Phone ____________________

Marital Status ❒ Single ❒ Married ❒ Partnered ❒ Widowed ❒ Divorced ❒ Separated

Parent #1 Name ____________________ (LAST, FIRST)

Date of Birth ____________________

Address if different than child ____________________

____

Home Phone ____________________

Cell Phone ____________________

Email ____________________

Employer ____________________

Work Phone ____________________

Insurance Co ____________________

Insurance Phone ____________________

Member ID # ____________________

Social Security # ____________________

Group # ____________________

Parent #2 Name ____________________ (LAST, FIRST)

Date of Birth ____________________

Address if different than child ____________________

____

Home Phone ____________________

Cell Phone ____________________

Email ____________________

Employer ____________________

Work Phone ____________________

Insurance Co ____________________

Insurance Phone ____________________

Member ID # ____________________

Social Security # ____________________

Group # ____________________

DENTAL HISTORY

Reason for today's visit

- ❒ First Check Up
- ❒ Regular Check Up, X-rays, Cleaning, Fluoride Treatment — why did you change dental offices? ____________
- ❒ Emergency Visit — please describe emergency ____________
- ❒ Referral from another dentist ____________ DENTIST NAME

Has your child had any unfavorable dental visits? ❒ Yes ❒ No If yes, please specify ____________

Has your child complained about any dental problems? ❒ Yes ❒ No If yes, please specify ____________

Does your child brush his/her teeth daily? ❒ Yes ❒ No

Does your child floss daily? ❒ Yes ❒ No

Any injuries to mouth, teeth or head? ❒ Yes ❒ No

Is fluoride taken in any form? ❒ Yes ❒ No

Does your child have any mouth habits? ❒ Thumb Sucking ❒ Nail Biting ❒ Mouth Breathing ❒ Sleep with Bottle ❒ Pacifier

What type of water does your child drink? ❒ City ❒ Well ❒ Bottled ❒ Filtered

MEDICAL HISTORY

Child's Physician ____________ Phone ____________

Date of Last Exam ____________ Results ____________

Is your child currently under a physician's care? ❒ Yes ❒ No If yes, for what? ____________

Has your child ever been hospitalized? ❒ Yes ❒ No If yes, for what? ____________

Is your child taking any medication or drugs? ❒ Yes ❒ No Please list ____________

____

Does your child have any allergies or had a negative reaction to

❒ Local Anesthetic ❒ Sulpha Drugs ❒ Codeine ❒ Latex

❒ Metal/Nickel ❒ Acrylic/Plastic ❒ Antibiotics ____________

Please list any other drugs, foods or things your child is allergic to ____________

____

Check any medical conditions that your child has been treated for or has had difficulty with:

❒ ADD/ADHD	❒ Cancer	❒ Hearing Impairment/Tubes	❒ Personality/Social Issues
❒ Aids/HIV	❒ Cerebral Palsy	❒ Heart Disease	❒ Physical Delays
❒ Anemia/Sickle Cell	❒ Cleft Lip/Palate	❒ Heart Murmur	❒ Rheumatic Fever
❒ Asthma	❒ Developmental Delay	❒ Kidney/Liver Disease	❒ Speech Issues
❒ Autism	❒ Diabetes	❒ Measles	❒ Thyroid Disease
❒ Bleeding Disorders	❒ Epilepsy or Seizures	❒ Mononucleosis	❒ Tobacco/Drug Use
❒ Birth Defects	❒ Fainting	❒ Mumps	❒ Tuberculosis

Please elaborate on any items checked or any health behavior issues we should know about ____________

____

Are there any other medical issues or conditions not listed that we should know about? ____________

____

Please certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the office of any changes in medical status.

✱ Signature of Parent/Guardian ____________ **Date** ____________

CONSENT FOR TREATMENT

I authorized the doctor or designated staff to take x-rays, study models and any other diagnostic aids deemed necessary to make a thorough diagnosis of the patient's dental needs. I also authorize photographs for the purpose of illustration or publication in professional journals or the advancement of teaching. I have been informed that patient identity will be protected at all times.

Upon diagnosis, I authorized the doctor and/or hygienist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware that this office provides optimal care as recommended by the ADA and my dental insurance may not cover certain procedures. It is my responsibility to be aware of what is covered by my insurance.

I agree to the use of anesthetics, including nitrous oxide, and other medications as necessary. I fully understand that the use of said agents imposes certain risks and realize that it is necessary to inform the doctor and staff of any drugs, including recreational drugs, which I may be taking in order to minimize these risks.

Please Note In the event of divorce situations, we will look to the parent / guardian who signs this form for payment unless we have these forms signed by the other parent and a letter that the other parent is accepting full responsibility for the services done to your child. It is our goal to provide your child optimal dental care and not get in the middle of divorce issues.

Child's Name ______________________________ **Parent/Guardian** ______________________________

PRINT NAME PRINT NAME

✱ Signature of Parent/Guardian ______________________________ **Date** ______________

FINANCIAL AND OTHER POLICIES

Payment I understand that payments for all services are to be paid at the time of service unless different payment arrangements are made in advance. We will work with you if we have confirmed dental insurance and collect only the **estimated** co-payment at the time of service. We make no guarantee that the amount we collect is accurate. We estimate the collected co-payment from historical data. If you want a more accurate estimate, ask to have a **pretreatment estimate** sent to your insurance company. We will gladly submit your insurance claim to your insurance. If we do not get paid within 30 days of submission of the claim we will look to you for full payment of your bill. Once we reach your annual maximum benefit, we will look to you for complete payment at the time of service unless a written payment plan has been made. We accept cash, checks, money orders and all major credit cards for your payments.

A service charge of 1.5% per month (18% per annum), but in no event more than the maximum rate permissible under state laws, will be charged on the unpaid principle balance on all accounts not paid within 60 days of the treatment date. I further understand the fee estimates listed for my dental care can only be extended for a period of six months from the date the estimate was written.

After 90 days from the date of service any unpaid accounts will be referred to a collection agency. I will then be responsible for my balance plus an additional 30% of the unpaid balance as the agency fee and any attorney's fees. I grant my permission to you, or your assigns, to phone me at my home or place of employment to discuss matters related to this form, my treatment or billing issues.

Assignment of Benefits I authorize my insurance company to pay directly to North Suburban Dental, benefits accruing to me under my policy. I understand that I am responsible for any charges not covered by my insurance.

Do not sign this if you have any questions about the financial or other policies of our offices. If you have any questions, ask one of our financial coordinators before signing this paper.

I have read the above Financial and Other Policies and agree to the content.

✱ Signature of Parent/Guardian ______________________________ **Date** ______________

North Suburban Dental Acknowledgment of Receipt of Notice of Privacy Practices Please notify the front desk if you refuse to sign this Acknowledgment.

I, ______________________________ have received a copy of the office's Notice of Privacy Practices.

PRINT NAME

✱ Signature of Parent/Guardian ______________________________ **Date** ______________

PATIENT PRIVACY AUTHORIZATION

INDIVIDUAL PATIENT

Patient Name ____

I, ______________________________________ give my authorization to use or disclose my or my child's
PRINT PARENT NAME
protected health information as described below.

USE AND DISCLOSURE

I understand that under HIPAA regulations, my dental/health information related to services rendered will be used and disclosed to any dental/health care provider who is involved with my or my child's dental/medical health treatment or services, my dental/medical insurance plan and any dental/medical billing clearinghouse who is involved with my insurance claim fulfillment.

Under these regulations, **the following people must be authorized by you to have access to your dental/health information** — your spouse; other family members and friends; nurse or home aid; legal guardian; or other person/organization who is not involved with your dental/medical treatment, insurance plan or payment.

Please list the people that you authorize to have access to your information.

Name ______________________ Phone ______________________

Address ______________________ Relationship to Patient ______________________

CIty ______________ Zip__________

Specific information to disclose ______________________ Expiration date of disclosure __________

Name ______________________ Phone ______________________

Address ______________________ Relationship to Patient ______________________

CIty ______________ Zip__________

Specific information to disclose ______________________ Expiration date of disclosure __________

CHANGING YOUR MIND ABOUT THE AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to your office.

METHOD OF CONTACT

I authorize the office of North Suburban Dental to contact me in the following manner.

❒ Home Phone ______________________
- ❒ Leave message with detailed information ❒ Leave message with call back number only

❒ Work Phone ______________________
- ❒ Leave message with detailed information ❒ Leave message with call back number only

❒ Cell Phone ______________________
- ❒ Leave message with detailed information ❒ Leave message with call back number only

❒ Email ______________________

❒ Written Mail ____

STATEMENT OF UNDERSTANDING

I have reviewed and I understand this authorization. I also understand that my or my child's dental/health information will be used or disclosed to certain business associates who are a part of the dental/health care process. These business associates will also keep your health information confidential.

✱ Signature of Parent/Guardian ______________________________ **Date** ______________