PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status ☐ Full Time ☐ Part Time ☐ Retired

Student Status ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Last cleaning appt.

Emergency contact

Emergency contact #

Primary physecian

Primary Physecian #

Primary Insurance Information

Name of Insured: Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Pediatric Medical History

Child's legal name: _____ Preferred name: _____ Date of birth: ___/___/____
Birth sex: ☐ M ☐ F Current gender identity: _____ Pronouns: ____ Race/Ethnicity: _____ Height: ___cm Weight: ___kg
Name/age and relationship of others living in the household: _____

Primary physician: _____ Address/phone: _____ Last visit: _____
Medical specialists: _____ Address/phone: _____ Last visit: _____

Is your child being treated by a physician at this time? Reason _____	☐ YES	☐ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?	☐ YES	☐ NO
List name, dose, frequency & date started: _____		
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?	☐ YES	☐ NO
List date & describe: _____		
Has your child ever had a reaction to or problem with an anesthetic? Describe _____	☐ YES	☐ NO
Have you been told your child needs antibiotics or another medicine before dental treatment? Reason _____	☐ YES	☐ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____	☐ YES	☐ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	☐ YES	☐ NO
Is your child up to date on immunizations against childhood diseases?	☐ YES	☐ NO
Is your child immunized against human papilloma virus (HPV)?	☐ YES	☐ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or at birth, prematurity, inherited conditions, syndromes, or birth defects (such as cleft lip/palate)	☐ YES	☐ NO
Problems with physical growth or development	☐ YES	☐ NO
Sinusitis, chronic adenoid/tonsil infections	☐ YES	☐ NO
Sleep apnea, snoring, or mouth breathing	☐ YES	☐ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	☐ YES	☐ NO
Irregular heart beat or high blood pressure	☐ YES	☐ NO
Asthma, reactive airway disease, wheezing, or breathing problems	☐ YES	☐ NO
Cystic fibrosis	☐ YES	☐ NO
Frequent colds or coughs, bronchitis, or pneumonia	☐ YES	☐ NO
Frequent exposure to tobacco smoke	☐ YES	☐ NO
Jaundice, hepatitis, or liver problems	☐ YES	☐ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	☐ YES	☐ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐ YES	☐ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder	☐ YES	☐ NO
Bladder or kidney problems or bedwetting	☐ YES	☐ NO
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis	☐ YES	☐ NO
Rash/hives, eczema, or skin problems	☐ YES	☐ NO
Impaired vision, visual processing, hearing, or speech	☐ YES	☐ NO
Developmental disorders, learning problems/delays, or intellectual disability	☐ YES	☐ NO
Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures	☐ YES	☐ NO
Autism/autism spectrum disorder or sensory integration disorder	☐ YES	☐ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness	☐ YES	☐ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)	☐ YES	☐ NO
Attention deficit/hyperactivity disorder (ADD/ADHD)	☐ YES	☐ NO
Behavioral, emotional, communication, or psychiatric problems/treatment	☐ YES	☐ NO
Abuse (physical, psychological, emotional, or sexual) or neglect	☐ YES	☐ NO
Diabetes, hyperglycemia, or hypoglycemia	☐ YES	☐ NO
Precocious puberty or hormonal problems	☐ YES	☐ NO
Thyroid or pituitary problems	☐ YES	☐ NO
Anemia, sickle cell disease/trait, or blood disorder	☐ YES	☐ NO
Hemophilia, bruising easily, or excessive bleeding	☐ YES	☐ NO
Transfusions or receiving blood products	☐ YES	☐ NO
Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant	☐ YES	☐ NO
Corona virus disease 2019 (COVID-19), cytomegalovirus (CMV), human immunodeficiency virus (HIV)/AIDS, methicillin-resistant staphylococcus aureus (MRSA), mononucleosis, scarlet fever, sexually-transmitted disease (STD), or tuberculosis (TB)	☐ YES	☐ NO

PROVIDE DETAILS HERE: _____

Is there any other significant medical history pertaining to this child or the child's family that the dentist should be told? ☐ YES ☐ NO
If YES, describe _____

What is your primary concern about your child's oral health? _____

How would you describe:

your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

your oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

the oral health of your other children? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Not applicable

Is there a family history of cavities? ☐ YES ☐ NO If yes, indicate all that apply: ☐ Mother ☐ Father ☐ Brother ☐ Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics	☐ YES	☐ NO	_____
Mouth sores or fever blisters	☐ YES	☐ NO	_____
Bad breath	☐ YES	☐ NO	_____
Bleeding gums	☐ YES	☐ NO	_____
Cavities/decayed teeth	☐ YES	☐ NO	_____
Toothache	☐ YES	☐ NO	_____
Injury to teeth, mouth, or jaws	☐ YES	☐ NO	_____
Clinching/grinding teeth	☐ YES	☐ NO	_____
Jaw joint problems (popping, etc.)	☐ YES	☐ NO	_____
Excessive gagging	☐ YES	☐ NO	_____
Sucking habit after one year of age	☐ YES	☐ NO	If YES, how long? _____ Which? ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other____

How often are your child's teeth brushed? _____ times per _____ Does someone help your child brush? ☐ YES ☐ NO

How often are your child's teeth flossed? ☐ Never ☐ Occasionally ☐ Daily Does someone help your child floss? ☐ YES ☐ NO

What type of toothbrush does your child use? ☐ Hard ☐ Medium ☐ Soft ☐ Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? ☐ City/community supply ☐ Private well ☐ Bottled water

Do you use a water filter at home? ☐ YES ☐ NO If YES, type of filtering system: _____

Please check all sources of fluoride your child receives:

❑ Drinking water ☐ Toothpaste ☐ Over-the-counter rinse ☐ Prescription rinse/gel ☐ Prescription drops/tablets/vitamins

❑ Fluoride treatment in the dental office ☐ Fluoride varnish by pediatrician/other practitioner ☐ Other: _____

Does your child regularly eat 3 meals each day?	☐ YES	☐ NO	
Is your child on a special or restricted diet?	☐ YES	☐ NO	If YES, describe: _____
Is your child a 'picky eater'?	☐ YES	☐ NO	If YES, describe: _____
Does your child have a diet high in sugars or starches?	☐ YES	☐ NO	If YES, describe: _____
Do you have any concerns regarding your child's weight?	☐ YES	☐ NO	If YES, describe: _____

How frequently does your child have the following?

Snacks between meals	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Product _____
Candy or other sweets	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Type _____
Chewing gum	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Usual snack _____
Soft drinks*	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Product _____

(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities? ☐ YES ☐ NO If YES, list: _____

Does your child wear a mouthguard during these activities? ☐ YES ☐ NO If YES, type: _____

Has your child been examined or treated by another dentist? ☐ YES ☐ NO

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? ☐ YES ☐ NO Date of most recent dental X-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ☐ YES ☐ NO If YES, when? _____

Has your child ever had a difficult dental appointment? ☐ YES ☐ NO If YES, describe: _____

How do you expect your child will respond to dental treatment? ☐ Very well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly

Is there anything else we should know before treating your child? ☐ YES ☐ NO

If yes, describe: _____

_____

Signature of parent/guardian | Relationship to child | Date | Signature of staff member reviewing history

MEDICAL/DENTAL HISTORY UPDATE

Is your child being treated by a physician at this time? Reason _____	☐ YES ☐ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?	☐ YES ☐ NO
List name, dose, frequency, & date started: _____	
Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year?	☐ YES ☐ NO
Describe: _____	
Has your child ever had a reaction to or problem with an anesthetic? Describe: _____	☐ YES ☐ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List: _____	☐ YES ☐ NO
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	☐ YES ☐ NO
Have there recently been any significant changes/disruptions to your child's family, home, or school routines?	☐ YES ☐ NO
Describe: _____	
What is your primary concern regarding your child's oral health? _____	
Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office?	☐ YES ☐ NO
Describe: _____	
Has your child's diet changed significantly since the last dental visit? Describe: _____	☐ YES ☐ NO
Has your child been treated by another dentist/dental professional since last visiting our office? Reason: _____	☐ YES ☐ NO
Is there any other change in the child's medical, dental, or family history that the dentist should be told?	☐ YES ☐ NO
Describe: _____	

_____

Signature of parent/guardian | Relationship to child | Date | Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER

Was your child born prematurely? ☐ YES ☐ NO If YES, what week? _____

What was your child's birth weight? _____

How long was your child breastfed? ☐ N/A ☐ less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

How long was your child bottle-fed? ☐ N/A ☐ less than 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

Do/did you feed your child infant formula? ☐ YES ☐ NO If YES, what type? (check one): ☐ Ready to use ☐ Powdered ☐ Liquid concentrate

Does/did your child sleep with a bottle? ☐ YES ☐ NO If YES, content of bottle? _____

Does/did your child use a no-spill training cup (sippy cup)? ☐ YES ☐ NO

Child's age (in months) when first tooth appeared in mouth _____

Has your child experienced any teething problems? ☐ YES ☐ NO

When did you begin brushing your child's teeth? ☐ N/A ☐ before age 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

When did you begin using toothpaste? ☐ N/A ☐ before age 6 months ☐ 6-11 months ☐ 12-17 months ☐ 18-23 months ☐ 2 years or more

Who is your child's primary care taker during the day? _____ during the evening? _____

Name/age of siblings at home: _____

_____

_____ _____ _____ _____

Signature of parent/guardian Relationship to child Date Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (to be completed by the patient)

For each YES response, please describe:

Do you have any concerns about your mouth, teeth, or oral health? ☐ NO ☐ YES _____

Have you recently experienced any dental/oral pain? ☐ NO ☐ YES _____

Do you have any concerns with the appearance of your teeth or smile? ☐ NO ☐ YES _____

Do you bleach your teeth? ☐ NO ☐ YES _____

Have there been any recent changes in your dietary habits? ☐ NO ☐ YES _____

Are you taking any dietary or herbal supplements? ☐ NO ☐ YES _____

Do you participate in sports or high speed activities (for example: skiing, four-wheeling, motorcycling)? ☐ NO ☐ YES _____

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of:

Oral habits (chewing fingernails, clenching/grinding teeth, etc.)	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.)	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Electronic cigarette (e-cig) use	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Eating disorder (anorexia, bulimia, etc.)	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Oral piercings/jewelry (including grill)	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Alcohol or recreational drug use/prescription abuse	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Inhalant use/abuse (such as huffing)	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Sexual activity (including oral sex)	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Abuse (physical, sexual, verbal, mental)	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Anxiety, depression, or feeling helpless/hopeless	☐ NO	☐ YES	☐ PREFER NOT TO ANSWER
Females: Are you pregnant or possibly pregnant?	☐ NO	☐ YES	

Is there anything you would like to discuss confidentially with your dentist? ☐ NO ☐ YES

Would you like to discuss a referral to a family dentist or general dentist because of your age? ☐ NO ☐ YES

_____ _____ _____

Signature of patient Date Signature of staff member reviewing history

Pediatric Dentistry Consultants

We value our availability for our patients, and we appreciate your communication with us. PLEASE call reschedule at least 24 hours prior to your appointment time and 48 hours PRIOR to your procedure if you are not able to attend.

Effective immediately, there will be a **$50 fee charged to you for any office visit cancelled within 24 hours** of scheduled appointment AND any NO SHOW appointments. There will be a **$100 fee** charged to you for any surgical procedure **cancelled with 24 hours** of scheduled procedure AND any NO SHOW procedures. This will NOT be charged to your insurance. All outstanding balances are expected to be paid prior to your next appointment.

Thank you,

Pediatric Dentistry Consultants

I have read and understand this no show/ cancellation policy and understand and agree to adhere to it. I understand the practice has a right to amend the policy as needed.

_____ _____

Signature of responsible policy Date

Pediatric Dentistry Consultants

Financial Policy

PLEASE READ THE FOLLOWING COMPLETELY:
The purpose of this form is to inform the parents or legal guardians of all our patients of our financial policies and your responsibility in regard to charges incurred in our practice. This form must be signed in order to proceed with the scheduled appointment. If you have any questions or concerns, please speak with the receptionist. Thank you.

If you do NOT have insurance: We ask that you pay for services at the time of your appointment.

If you have a PPO insurance plan: Please give your insurance card and any necessary information to the receptionist prior to the start of your appointment. You may be required to make a payment (co-payment, partial payment, deductible, etc.) for your visit today.

If you have an HMO or DHMO insurance plan: Please give your insurance card and referral (if required by your plan) from your primary dentist to the receptionist. The referral form must come from your primary dentist in order for your claim to be considered for payment by your insurance company. If we are not contracted with your plan or you did not receive a referral from your primary care dentist, you will be responsible for the cost of services rendered at the time of visit.

Reminder: The agreement of the insurance company to pay for dental care is a contract between you and your insurance company. The responsibility for total cost for treatment rests with the patient's parent or legal guardian. Most insurance policies involve deductibles, maximums and percentage allowances with the result that that the entire bill is seldom covered in full. While we do verify your benefits and recent dental history with your insurance company we can only give you an **ESTIMATE** of your out of pocket cost for treatment. We cannot guarantee payment of any kind from your insurance company. You may have outstanding claims that affect the amount your insurance company pays on the claims received by our office and your plan might allow for alternate benefits on certain procedures. In the event your insurance company indicates that you owe over what we estimated, you will be billed for the remaining portion due. Any accounts credits as the result of patient overpayment will be refunded upon request.

Payment of services: Payment is expected at the time services are rendered. If treatment requires multiple appointments, payments may be divided over the number of appointments required to complete the treatment. If an extended payment plan is desired, please ask us about CareCredit. For your convenience we accept the following forms of payment: cash, check, Visa, Mastercard, Discover or American Express.

Patient balances over 30 days will incur an interest charge of 1.5% monthly (18% annually) and a $5.00 rebilling fee per statement. Returned checks will have an additional $35.00 added to the amount of the returned check and may result in our office declining future check payment. Balances over 90 days will be referred to an outside collection agency. If the account is referred to an outside collection agency you will be responsible for any and all collection agency fees, attorney fees and court fees.

Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. This office is a private dental practice dental office and not a dental "clinic". Appointment time is reserved for your child alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your child's dental care. When you make an appointment, please be sure that you will be able to keep it.
Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If your child has a dental emergency that needs immediate attention, we will always offer to see them at once. We expect that other patients who might be slightly inconvenienced by this will be understanding of the situation. At some point, they may need the same courtesy too!
Like many offices, this office does call to confirm your appointment. Pease make a note of any dental appointments we have scheduled in a place where you will be reminded. If you cannot make an appointment as scheduled, please notify the office. There will be a charge of $25.00 per 30 minutes of scheduled time for a broken appointment or cancellation with less than 24 hours' notice for any appointments scheduled Monday thru Friday and a flat fee of $100.00 for any Saturday appointment. If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.

Our office reserves the right to make changes in the above policies at any time deemed necessary and without notice.

I have read the above policies completely. I understand and agree to all of the terms of the policies.

Patient Name	Guarantor Signature	Date

Pediatric Dentistry Consultants
1828 Bay Scott Cir. Suite 112
Naperville, IL 60540

HIPAA Signature Form

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Pediatric Dentistry Consultants. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Pediatric Dentistry Consultants reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

PRINT Name(s) of Patient(s)	PRINT Name of Personal Representative/Relation
SIGNATURE of Personal Representative	Today's Date