Booe pediatric dentistry

Patient Registration

CHILD'S INFORMATION:

First Name: ______________________ Last Name: ______________________ Preferred Name: ______________________

Date of Birth: ______________________ Sex: ☐ Male ☐ Female Age: ______________________

Address: ____
City State Zip

Student? ☐ Yes ☐ No School Name: ______________________________________

Who may we thank for your referral? ______________________________________

RESPONSIBLE PARTY:

First Name: ______________________ Last Name: ______________________ Date of Birth: ______________________

Mailing Address: ____
City State Zip

Email: ______________________ Home Phone: ______________________ Cell Phone: ______________________

Employer: ______________________ Occupation: ______________________ Social Security #: ______________________

Relationship to patient: ______________________ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated

Do you have legal custody of this child? ☐ Yes ☐ No If No, who does? ______________________

INSURANCE:

Primary Insurance
Name of Insured:______________________
DOB of Insured:______________________
SSN of Insured:______________________
Name of Employer:______________________
Name of Insurance Company:______________________
Group ID #:______________Subscriber ID #:______________

Secondary Insurance
Name of Insured:______________________
DOB of Insured:______________________
SSN of Insured:______________________
Name of Employer:______________________
Name of Insurance Company:______________________
Group ID #:______________Subscriber ID #:______________

CERTIFICATE OF INFORMATION:

Patients are seen by appointment only. Appointments are reserved to ensure that adequate time is allowed to provide your child with the best possible care and outcome. If you are 15 minutes late to your appointment, you may be asked to reschedule your appointment. Cancellation of appointments must be made at least twenty-four hours in advance. If you no show/no call two appointments, you will be dismissed from our practice. A legal parent or guardian must accompany patients for each visit. Children who are not accompanied by a legal guardian may not be able to receive the care they have been scheduled for. We make every effort to keep the cost of your dental care down. Payment arrangements can be made with our Financial Coordinator depending upon special circumstances. An **estimate** of the charge for any procedure or surgery you may require will be given to you. If you have medical and/or dental insurance, we will be glad to file a claim on your behalf. Please complete the insurance section above. Please remember that insurance is considered a method of assisting in the cost of care and is not a guarantee of payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance and any other balance not paid by your insurance company at time of the procedure. Past due balances are subject to a monthly finance charge. If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including but not limited to interest, rebilling fees, court costs, attorney fees, and collection agency costs. This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the provider named on the insurance benefits form unless otherwise stated payable to me.

Signature: ______________________________________ Date: ______________________

Acknowledgement of Notice of Privacy Practices

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

Printed Name:______________________
Signature:______________________
Date:______________________

Medical and Dental History

DENTAL HISTORY:

Has your child ever been to a dentist? ☐ Yes ☐ No Date of last x-rays (if taken):____________________

Name of dentist and date____________________

Has your child experiences any unfavorable reaction from previous dental care? ☐ Yes ☐ No

Explain:____________________

Does your child suck a finger, thumb, or pacifier? ☐ Yes ☐ No

Does your child use a bottle or sippy cup? ☐ Yes ☐ No If yes, what does he/she drink in them?____________________

Please check if your child is having problems with any of the following:

☐ Cavities ☐ Toothache ☐ Sensitive teeth ☐ Trauma ☐ Gum infections

☐ Color of teeth ☐ Orthodontics ☐ Jaw sounds ☐ Other

Comments:____________________

Please estimate your child's daily exposure to the following items:

Soda:__________ Juice:__________ Sports Drinks:__________

Fruit snacks/fruit roll-ups:__________ Chips:__________ Cookies/crackers:__________

MEDICAL HISTORY:

Name of child's Physician: ____________________ Phone: ____________________

Is your child in good health? ☐ Yes ☐ No Date of last physical exam:____________________

Has your child ever had a health problem? ☐ Yes ☐ No If yes, please explain: ____________________

Is your child current on their vaccinations? ☐ Yes ☐ No If no, please explain:____________________

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, please explain:____________________

Is your child allergic to anything? ☐ Yes ☐ No Please list: ____________________

Is your child currently taking any medications? ☐ Yes ☐ No Please list medication(s), dose and reason:

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Were there any problems with pregnancy or at birth? ☐ Yes ☐ No If yes, please explain: ____________________

Please indicate if your child has been diagnosed with or treated for any of the following:

☐ Congenital Heart Defect	☐ Seizures/Epilepsy	☐ Sickle Cell Trait/Disease	☐ Skin rashes/Hives/Cold Sores
☐ Heart Surgery	☐ Autism	☐ Hemophilia/Anemia	☐ Muscle/Bone/Joint Problems
☐ Heart Murmur	☐ ADD/ADHD	☐ Kidney/Liver Problems	☐ Eating Disorder
☐ High Blood Pressure	☐ Learning/Communication Problems	☐ Diabetes	☐ Hepatitis A, B, C
☐ Asthma/Breathing Issues	☐ Visual/Hearing Impairment	☐ Failure to Thrive	☐ Blood Transfusion
☐ Cerebral Palsy	☐ Abnormal Bleeding Issues	☐ Thyroid/Glandular Problems	☐ HIV/AIDS

☐ Syndrome:____________________

Please elaborate on any items marked or items not noted but need further clarification____________________

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FLUORIDE HISTORY:

Is your home water supply fluoridated? ☐ Yes ☐ No

Does your child use fluoride toothpaste? ☐ Yes ☐ No

Does your child participate in a school fluoride rinse program? ☐ Yes ☐ No

Do you give your child any other form of fluoride? ☐ Yes ☐ No

If so, what kind of fluoride?____________________

CONSENT FOR DENTAL TREATMENT:

I request and authorize Dr. Booe to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Booe &/or staff to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr Booe will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Legal Guardian Signature:____________________ Date:____________________