FOOTHILLS PEDIATRIC DENTISTRY
PATIENT REGISTRATION AND HEALTH HISTORY FORM

I. Social History

Child's Full Name: _____ Preferred Name: _____
Age: _____ Date of Birth: _____ Sex: □ Male □ Female
Mailing Address: _____
City: _____ State: _____ Zip: _____

Name of Parent / Legal Guardian: _____
Relation to Child: _____ Home Phone #: _____
Cell Phone #: _____ Email Address: _____

Name of Parent / Legal Guardian: _____
Relation to Child: _____ Home Phone #: _____
Cell Phone #: _____ Email Address: _____

Name of Emergency Contact (other than parent): _____
Relation to Child: _____ Home Phone #: _____
Cell Phone #: _____

Child lives with (please check all that apply): □ Both parents □ Mother □ Father
□ Stepmother □ Stepfather □ Grandparent □ Other_____

Other children in the family:
1. Name: _____ Age: _____
2. Name: _____ Age: _____
3. Name: _____ Age: _____
4. Name: _____ Age: _____
5. Name: _____ Age: _____

How did you hear about our office?
□ Referred by Friend or Family – Name: _____
□ Referred by General Dentist – Name: _____
□ Referred by Pediatrician – Name: _____
□ Upstate Parent Magazine
□ Belle Magazine
□ Website
□ Phone Book
□ Other_____

II. Dental History

What is the reason for your child's dental visit?
□ Exam □ Cleaning □ Cavities □ Toothache □ Trauma □ Concern about appearance of teeth
□ Other_____

□ Yes □ No Has your child ever been to the dentist?
If yes, what was the name of their previous dentist? _____
If yes, when was their last cleaning? _____
If 6 years of age or older, when was their last panoramic x-ray? _____
□ Yes □ No Does your child go to bed with a bottle or sippy cup?
□ Yes □ No Is your child at least 2 years of age and still using a pacifier?
□ Yes □ No Does your child suck their thumb or fingers?
□ Yes □ No Does your child frequently get sugary drinks or snacks between meals?
If yes, please list their favorite drinks or snacks: _____
□ Yes □ No Has your child ever had an accident that involved their teeth?
Is yes, please explain: _____
□ Yes □ No Has your child ever received oral sedation for dental treatment?
If yes, were there any problems? _____
□ Yes □ No Has your child ever received general anesthesia for dental treatment?
If yes, were there any problems? _____
□ Yes □ No Has any family member had a bad reaction to general anesthesia?
If yes, please explain: _____

III. Medical History

□ Yes □ No Does your child have any health problems or have they previously had any health problems?
If yes, please list: _____
□ Yes □ No Is your child taking any medications?
If yes, please list medication(s) and condition(s) being treated:
1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
□ Yes □ No Is your child allergic to Latex?
□ Yes □ No Is your child allergic to any drugs?
If yes, please list: _____
□ Yes □ No Has your child been hospitalized, had surgery, or had to go to the emergency room? If yes, please explain: _____
□ Yes □ No Have your ever been told that your child needs to take antibiotics before dental treatment to prevent infection in their heart?
Please check if your child has been diagnosed with or treated for any of the following:

- ☐ Hearing Problems
- ☐ Eye/Vision Problems
- ☐ Speech Problems
- ☐ Recurrent Ear Infections
- ☐ Tonsil/Adenoid Problems
- ☐ Cleft Lip/Palate
- ☐ Snoring
- ☐ Obstructive Sleep Apnea
- ☐ Congenital Heart Defect
- ☐ Endocarditis
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Sickle Cell Anemia
- ☐ Bleeding Disorder / Hemophilia
- ☐ Rheumatic Fever
- ☐ HIV/AIDS
- ☐ Hay Fever (Seasonal Allergies)
- ☐ Asthma
- ☐ Cystic Fibrosis
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Gastrointestinal Problems
- ☐ Liver Problems
- ☐ Kidney Problems
- ☐ Autism
- ☐ Cerebral Palsy
- ☐ Spina bifida
- ☐ Seizures
- ☐ ADD/ADHD
- ☐ Developmental Delay
- ☐ Arthritis
- ☐ Diabetes
- ☐ Cancer/Tumors
- ☐ Abuse
- ☐ Herpetic Ulcers (Cold Sores)
- ☐ Aphthous Ulcers (Canker Sores)
- ☐ Syndrome _____
- ☐ Other_____

Health History Summary (to be completed by the doctor)

IV. Consent for Dental Treatment

I, _____, affirm that the above information is correct to the best of my knowledge. I understand that it is my responsibility to inform Foothills Pediatric Dentistry of any changes in my child's health.

I consent to the performance of a diagnostic exam, x-rays, cleaning, and fluoride treatment upon my child as deemed appropriate by Foothills Pediatric Dentistry.

Signature of Parent / Legal Guardian: _____
Date: _____

FOOTHILLS PEDIATRIC DENTISTRY
INSURANCE FORM

Child's Name: _____ Date of Birth: _____ SSN: _____

Primary Dental Insurance

Name of Insured: _____ Relation to Child: _____
Insured's SSN: _____ Insured's Date of Birth: _____
Employer: _____
Employer Address: _____
Insurance Company: _____ ID #:_____ Group #:_____
Insurance Company Address: _____

Secondary Dental Insurance

Name of Insured: _____ Relation to Child: _____
Insured's SSN: _____ Insured's Date of Birth: _____
Employer: _____
Employer Address: _____
Insurance Company: _____ ID #:_____ Group #:_____
Insurance Company Address: _____

Medicaid

Exact Spelling of Name on Card: _____
Medicaid ID #:_____

FOOTHILLS PEDIATRIC DENTISTRY
HIPAA FORM

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Child's Full Name: _____ Date of Birth: _____

To whom may we release your child's identifying health information?

Child's Medical Doctor: _____
Office Address: _____
City: _____ State: _____ Zip: _____
Office Phone #: _____ Office Fax #: _____

Name: _____ Relation to Child: _____
Home Phone #: _____ Cell Phone #: _____
Email Address: _____

Name: _____ Relation to Child: _____
Home Phone #: _____ Cell Phone #: _____
Email Address: _____

Name: _____ Relation to Child: _____
Home Phone #: _____ Cell Phone #: _____
Email Address: _____

Name: _____ Relation to Child: _____
Home Phone #: _____ Cell Phone #: _____
Email Address: _____

I authorize Foothills Pediatric Dentistry to release my child's identifying health information to the individuals/offices listed above.

Name of Parent / Legal Guardian: _____
Signature of Parent / Legal Guardian: _____
Date: _____

FOOTHILLS PEDIATRIC DENTISTRY
OFFICE POLICIES

Your scheduled appointment time has been reserved specifically for you. We request that you call us two days in advance if you need to reschedule your appointment. If you fail to cancel with 24 hours notice or do not show up for your appointment, you may be subject to a $25 broken appointment fee per child that must be paid before future appointments are scheduled.

A parent or legal guardian (with official documentation) must be present for all appointments. Please complete all the paperwork before you arrive so that we can get your child back on time. If you are 15 minutes late for your appointment, you may be asked to reschedule so that we are not running behind for the next patient. If there are two no shows or two cancellations without 24 hours notice, we reserve the right to no longer see your child in our office.

Due to the amount of time reserved for a sedation appointment, we require a $100 reservation fee. This fee will be applied toward the total cost of the sedation. If you fail to cancel with 24 hours notice or do not show up for your appointment, you will not be reimbursed even if you schedule another sedation appointment.

One parent is encouraged to remain with the child for the entire appointment. Other children who are not being seen are asked to remain in the reception area with another adult. Please do not bring strollers into the back of the office.

Food, drinks and the use of cell phones is not allowed in the office.

We will make every effort to be on time for your child's appointment. An emergency patient can sometimes cause a slight delay, but we will work hard to get back on schedule. School and work excuses will gladly be provided if requested.

I understand and agree to comply with the office policies of Foothills Pediatric Dentistry.

Name of Parent / Legal Guardian: _____
Signature of Parent / Legal Guardian: _____
Date: _____

FOOTHILLS PEDIATRIC DENTISTRY
FINANCIAL POLICIES

These policies are followed by our practice so that we can stay focused on what we do best, providing your child with the highest quality dental care in a loving and compassionate environment. Please let us know if you have any questions regarding these policies.

1. The patient's estimated portion for services rendered is due in full the day of the appointment unless other arrangements have been made in advance.

2. For your convenience, we accept cash, check, MasterCard, Visa, and Discover.

3. Fees quoted on the treatment plan will remain in effect for 90 days and thereafter are subject to change without notice.

4. If the treatment plan needs to be modified for clinical or behavioral reasons, the treatment modifications, including the associated costs, will be discussed with you prior to proceeding with the modified treatment plan.

5. If you fail to cancel with 24 hours notice or do not show up for your appointment, you may be subject to a $25 broken appointment fee per child that must be paid before future appointments are scheduled.

6. If your check is returned due to insufficient funds or otherwise, a $25 returned check fee will be added to the amount due.

7. As a courtesy, we will file your insurance, but since your insurance is a contract between you and your insurance company, we cannot assume responsibility for the percentage of services covered. You will be asked to pay your estimated portion the day of the appointment, but you are ultimately responsible for paying anything that insurance has not paid within 30 days of the appointment.

8. If your estimated portion is 30 days past due, you will be charged interest on the outstanding amount retroactive to the day of service at a rate of 10% per month. If your estimated portion is 30 days past due, you may be referred to a collection agency or attorney and will be responsible for all fees associated with collecting the past due amount.

I understand and agree to comply with the financial policies of Foothills Pediatric Dentistry.

Name of Parent / Legal Guardian: _____
Signature of Parent / Legal Guardian: _____
Date: _____