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# WELCOME to our practice



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## Patient Registration & History

### Patient Information

Date: \_\_\_\_\_ ID/SS#: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Child: \_\_\_\_\_  
Last Name First Name MI

Gender  M  F Age: \_\_\_\_\_ Nickname: \_\_\_\_\_ Hobbies/Interest: \_\_\_\_\_

Child's Home Address: \_\_\_\_\_  
Street City State Zip

Mailing Address (if different): \_\_\_\_\_  
Street City State Zip

Language: \_\_\_\_\_ Race: \_\_\_\_\_ Ethnicity: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Person Financially Responsible: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Whom may we thank for referring you?  Drive By  Internet  Direct Mail  Insurance Plan  School/Daycare  Friend/Family  Other:

Referring Patient Name: \_\_\_\_\_ Referring GP/Dr. Name: \_\_\_\_\_

### Insurance Information

Mother's/Guardian's Name: _____ <input type="radio"/> Mother <input type="radio"/> Stepmother <input type="radio"/> Guardian	Father's/Guardian's Name: _____ <input type="radio"/> Father <input type="radio"/> Stepfather <input type="radio"/> Guardian
Address (if different from patient's): _____	Address (if different from patient's): _____
DOB: ____/____/____ SS# _____	DOB: ____/____/____ SS# _____
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
Home Phone: _____	Home Phone: _____
Cellphone: _____	Cellphone: _____
Work Phone: _____	Work Phone: _____
Email: _____	Email: _____
Do you have dental insurance coverage for minor/child? <input type="radio"/> Yes <input type="radio"/> No	Do you have dental insurance coverage for minor/child? <input type="radio"/> Yes <input type="radio"/> No
Plan Name: _____ Phone: _____	Plan Name: _____ Phone: _____
Address: _____	Address: _____
Group #: _____ Policy #: _____	Group #: _____ Policy #: _____

If your child is eligible for treatment under Medical Assistance, please enter their Medical Assistance ID#: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Patient Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Dental History

Date of last dental visit: \_\_\_\_\_ For what service?: \_\_\_\_\_

- Has your child complained about dental problems?  Yes  No    Is fluoride taken in any form (including water supply)?  Yes  No
- Does your child brush his or her teeth daily?  Yes  No    Has your child had any mouth, teeth or head injuries?  Yes  No
- Does your child floss his or her teeth daily?  Yes  No    Has your child had any unhappy dental experiences?  Yes  No
- Does your child grind his or her teeth?  Yes  No    Is your child experiencing any dental pain?  Yes  No
- Does your child have any mouth habits (thumbsucking, nail biting, mouth breaking, pacifier, sleeping with bottle, etc.?)  Yes  No

## Medical History

Minor/Child's Physician: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_ Results: \_\_\_\_\_

- Is your child under the care of a physician now??  Yes  No    Please list any medications your child is taking: \_\_\_\_\_
- Is your child taking any medication or drugs?  Yes  No    \_\_\_\_\_
- Does your child experience excessive bleeding?  Yes  No    \_\_\_\_\_
- Has your child had any hospital stays or surgeries?  Yes  No    Please list ALL of your child's allergies: \_\_\_\_\_

Please explain: \_\_\_\_\_

Smoking / Tobacco: Yes No Explain: \_\_\_\_\_

Does your child have any history of or difficulty with any of the following?

- |             |  |                    |  |                    |  |                     |  |                     |  |                 |  |
|-------------|--|--------------------|--|--------------------|--|---------------------|--|---------------------|--|-----------------|--|
| AIDS/HIV    | <input type="radio"/> Yes <input type="radio"/> No | Behavioral issues  | <input type="radio"/> Yes <input type="radio"/> No | Convulsions        | <input type="radio"/> Yes <input type="radio"/> No | Heart problems      | <input type="radio"/> Yes <input type="radio"/> No | Measles             | <input type="radio"/> Yes <input type="radio"/> No | Sinus problems  | <input type="radio"/> Yes <input type="radio"/> No |
| ADD/ADHD    | <input type="radio"/> Yes <input type="radio"/> No | Blood disorders    | <input type="radio"/> Yes <input type="radio"/> No | Diabetes           | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia          | <input type="radio"/> Yes <input type="radio"/> No | Mononucleosis       | <input type="radio"/> Yes <input type="radio"/> No | Skin rash/hives | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis | <input type="radio"/> Yes <input type="radio"/> No | Blood transfusions | <input type="radio"/> Yes <input type="radio"/> No | Drug/alcohol abuse | <input type="radio"/> Yes <input type="radio"/> No | High blood pressure | <input type="radio"/> Yes <input type="radio"/> No | Mumps               | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis     | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia      | <input type="radio"/> Yes <input type="radio"/> No | Cancer             | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy           | <input type="radio"/> Yes <input type="radio"/> No | Kidney problems     | <input type="radio"/> Yes <input type="radio"/> No | Neurological issues | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis    | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma      | <input type="radio"/> Yes <input type="radio"/> No | Chicken pox        | <input type="radio"/> Yes <input type="radio"/> No | Fainting           | <input type="radio"/> Yes <input type="radio"/> No | Leukemia            | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever     | <input type="radio"/> Yes <input type="radio"/> No | Other           | <input type="radio"/> Yes <input type="radio"/> No |
| Autism      | <input type="radio"/> Yes <input type="radio"/> No | Cleft lip/palate   | <input type="radio"/> Yes <input type="radio"/> No | Hearing impairment | <input type="radio"/> Yes <input type="radio"/> No | Liver disease       | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell/Trait   | <input type="radio"/> Yes <input type="radio"/> No | _____           | _____  |

## Emergency Contact

In the event of an emergency, whom should we contact? (Other than parent/guardian.)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #(s): \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #(s): \_\_\_\_\_

Minor/child consent: I am the parent, guardian or personal representative of \_\_\_\_\_ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including, but not limited to, x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Please Print Name of Child/Minor

I certify that I am covered by insurance with \_\_\_\_\_ and assign directly to Lancaster Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby authorize Lancaster Pediatric Dentistry to release all information necessary to secure the payment of benefits.

Name of Insurance Company (if applicable)

To the best of my knowledge, I certify that the above information is complete and correct. I understand that it is my responsibility to inform this office of any changes in my child's medical status or any other information provided in this form.

Signature of Parent, Guardian or Personal Representative

Date

Please Print Name of Parent, Guardian or Personal Representative

Relationship to Patient

## HIPAA RELEASE AND ACKNOWLEDGEMENT

Consent for Use or Disclosure of Patient's Protected Health Information

**Patient Last Name** \_\_\_\_\_ **First Name** \_\_\_\_\_ **Middle** \_\_\_\_\_

**Birthdate** \_\_\_\_\_

• I hereby authorize Lancaster Pediatric Dentistry to release information for dental claims, prescriptions, diagnostic treatment, and care management services, and for reviews required by HHS or HIPAA-compliant operations via reasonable methods including but not limited to phone, fax, mail, electronic mail, and friend/relative/caregiver. If I provide an email address, I am able to receive email securely and away from a public computer.

• I hereby authorize the designated parties below to request and receive protected health information regarding my child's dental treatment, dental findings, billing, payment or administrative operations related to dental treatment. I understand that the identity of designated parties must be verified before the release of any information occurs. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Friend, Relative, and/or Caregiver (Agent) who may bring your child for care and may be provided HIPAA protected information about your child (Please list below):

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Relationship \_\_\_\_\_

• Given the layout of our office, from time to time, conversations may be overheard by others. If you object to the fact that you may overhear other patient's health information, or that your child's health information may be overheard by another, please let us know and we will be sure to either place you in a completely private room or reschedule your appointment according to your needs.

CONSENT I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my child's rights are identified in the practice's Notice of Privacy Practices.

### AUTHORIZATION

I hereby authorize Lancaster Pediatric Dentistry, to give, disclose and release to my agent/s who are named herein and who are currently serving as such, without restriction, all of my child's individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment.

Additionally, this disclosure shall include the ability to ask questions and discuss this protected medical information with the person or entity who has possession of the protected medical information. It is my intention to give a full authorization to any protected medical information to my agent/s.

The authority given to my agent shall supersede any prior agreement that I may have made with my health-care provider to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to agent/s may be subject to redisclosure by my agent/s and may no longer be protected by HIPAA.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_