Patient Registration Form

Patient Name ____
First Middle Last

Home Address____

City: ___________________________ State: _________________________ Zip Code: ___________________________

Date of Birth ____________________ SS#_____________________ (optional) Male______ Female______

Home Phone: ______________________________________ Cell Phone: _______________________________________

Whom may we thank for referring to our office? ____

Parent/Foster Parent/Legal Guardian Information

Name: ____ Relationship: ___________________DOB: ________________

Social Security #: _____________________ Email: _________________________ Married: ____ Single: ___ Div.:____

Home Phone: ______________________________________ Cell Phone: _______________________________________

Home Address (if different than child): ____

City: ___________________________ State: _________________________ Zip Code: ___________________________

Employer: ____ Occupation: _______________________________________

Parent/Foster Parent/Legal Guardian Information

Name: ____ Relationship: ___________________DOB: ________________

Social Security #: _____________________ Email: _________________________ Married: ____ Single: ___ Div.:____

Home Phone: ______________________________________ Cell Phone: _______________________________________

Home Address (if different than child): ____

City: ___________________________ State: _________________________ Zip Code: ___________________________

Employer: ____ Occupation: _______________________________________

Primary Dental Insurance

Insurance Company______________________________________ Relationship to patient_________________________

Policy Holder's Name ____ Date of Birth __________________________

Social Security #____ Subscriber's ID ____________________________

Secondary Dental Insurance

Insurance Company______________________________________ Relationship to patient_________________________

Policy Holder's Name ____ Date of Birth __________________________

Social Security #____ Subscriber's ID ____________________________

Bright Starr PEDIATRIC DENTISTRY

Medical History

What are your concerns? Circle as many as applicable:

Pain Avoidance | Losing Teeth | Thumb Sucking Habit
Cavities | Routine Checkup | Nutrition/Diet Counseling
Cosmetic Appearance | Accidental Injury | Other__________________

Has your child ever been to the dentist? : ☐ Yes ☐ No (If Yes) Date Last Exam: ________________________________

Do you think your child will react well to treatment? : ☐ Yes ☐ No Why: _______________________________________

Please describe any tips/tricks that will help our team provide a positive experience for your child's visit:

____

Does your child currently… (Check all that apply)

☐ Suck Thumb/Finger ☐ Suck/Bite Lips ☐ Bite/Chew Nails ☐ Tongue Thrust ☐ Bottle Feed
☐ Use Pacifier ☐ Tongue/Cheek Chew ☐ Clench/Grind Teeth ☐ Mouth Breather ☐ Breast Feed

☐ Fluoride Toothpaste ☐ Consume Fluoridated Water ☐ Brushing by Child:___/day ☐ Brushing by Parent:__/day
☐ Snack between Meals --Type of snacks: __________________ ☐ Fluoride Mouthwash ☐ Dental Floss:_____/week

Has your child been diagnosed and/or treated for any of the following… (Check all that apply)

☐ Blood Disorder/Anemia
☐ Abnormal Bleeding/Hemophilia
☐ Immune Disorder/HIV/AIDS
☐ Cancer/Tumor/Leukemia
☐ Heart Murmur/Defect/Surgery
☐ Epilepsy/Seizures/Convulsions
☐ Cerebral Palsy
☐ Cystic Fibrosis
☐ Kidney Problems
☐ Liver Disease/Jaundice/Hepatitis
☐ Diabetes
☐ Sickle Cell Trait or Disease
☐ Stomach/GI Disorders
☐ Down Syndrome
☐ Thyroid Trouble or goiter

☐ Tuberculosis (TB)
☐ Asthma/Reactive Airway/ Hay Fever
☐ Tonsillitis
☐ Congenital Birth Defects
☐ Premature/Low Birth Weight
☐ Cleft Lip/Palate
☐ Autism Spectrum
☐ ADD/ADHD
☐ Eating Disorder
☐ Speech Disorder
☐ Vision Problems
☐ Hearing Problems/Deaf
☐ Mental/Cognitive/Social Delay
☐ Chronic Sinusitis
☐ Arthritis

ALLERGIES:

☐ Drug: ____________________________
☐ Penicillin
☐ Novocain
☐ Food: ____________________________
☐ Seasonal
☐ Hives
☐ Latex
☐ Other (specify): ______________________

Patient is taking:

☐ Insulin
☐ Inhaler or Nebulizer
☐ Antibiotic

Are immunizations current? : ☐ Yes ☐ No

Primary Physician_____________________________Phone_________________________ Last Visit________________

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain): ____________________

Current Medications: ____

Has your child ever had abnormal bleeding following a cut or extraction: ☐ Yes ☐ No

Has your child ever had anesthetic (either local or general): ☐ Yes ☐ No

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status.

_________________________________ _________________________________ ____________________________

Signature of Patient or Legal Guardian **Patient/Legal Guardian Name Printed** **Childs Name**

Regarding Dental Insurance

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense. **Insurance is a method of payment not a method of treatment.** Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.
We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. A better term for dental insurance may be "dental assistance".

Please remember, however, the financial obligation for dental treatment is between you and this office, and is not between this office and your insurance company.

It often takes us a considerable amount of time to try to collect your insurance payment for you. We often need your help to discuss your situation directly with your insurance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, we cannot render services on the assumption that our charges will be paid by an insurance company. In addition, this form also authorizes this practice to submit insurance claim forms and receive payments directly from the Insurance carrier with the notation “SIGNATURE ON FILE”.

Financial Agreement

If an account is outstanding for more than sixty (60) days, a monthly service charge of 1.5% may be added to the balance. If the account is not cleared within the time specified, the account will be turned over to our collection service with additional charge of 25% towards the pending balance and a report may be filed with a credit servicing agency, such as Equifax. **Insurance co-payments and deductibles are due at the time of service.**

I Understand That Payment Is Due At Time of Service

Signature of Patient or Legal Guardian ____ **Date**______________________

Consent

I hereby authorize and direct the dentists of Bright Starr Pediatric Dentistry and/or dental auxiliaries of their choice:

Yes No

☐ ☐ To perform upon my child (or legal ward) treatment that is necessary or recommended, **after review of treatment plan**
☐ ☐ To release treatment records/ x-rays or any other information deemed pertinent to my insurance carrier as necessary and / or requested
☐ ☐ To telephone me at home, work or text message to my cell or emails, to discuss matters related to this form or treatment of my child
☐ ☐ I will bring all future changes in my child's medical history to the attention of the doctor. I understand that providing incorrect information can be dangerous to my child's health.
☐ ☐ The right to take photographs of my child, and to use and publish the same in print and/or electronically (post on Facebook or teaching purposes)
☐ ☐ To release information about invoice or accounts payable upon request, to patient/legal guardian
☐ ☐ Digital x-rays, referrals and/or orders to a dental specialist/medical physician about treatment

I have read and understand the above and acknowledge that I have been given or offered a copy of the offices “Notice of Privacy Practices”.

______________________________	______________________________	______________________________
Signature of Patient or Legal Guardian	**Patient/Legal Guardian Name Printed**	**Childs Name**

Office Policies

Cancellation/Broken Appointment

Your time is as valuable as ours. We make every effort to see you at your reserved time. We apologize in advance if you are not seen exactly at your scheduled time; please understand that we do try to work- in dental emergencies.

As a courtesy we attempt to confirm each scheduled appointment, however, as the patient you are responsible to keep up with your reserved time and are still subject to the cancellation/ broken appointment fee should you not make it to your appointment. **INSURANCE COMPANIES DO NOT PAY YOUR BROKEN APPOINTMENT FEES**. Please inform us if any address or contact information needs to be updated. **The office must be notified within 48 business hour if you wish to make any changes to your scheduled appointment.**

Extensive Treatment Scheduling

Patients are required to place a deposit of $50 before/during appointment scheduling for all treatment other than routine dental cleaning. This fee will be applied towards your treatment fees/balance after treatment. Should you miss your appointment without cancellation 48 hours before; your deposit will be forfeited.

Privilege of a Saturday Appointment

At Bright Starr Pediatric Dentistry, we understand how difficult it can be for parents and their children to find time for scheduling dental appointments. After school activities, sports teams, work, family and social obligations all require time from packed schedules. Our flexible scheduling is part of our dedication to serving our patients and their families. We want you to get the pediatric dental care your child needs, when you need it. We understand that illness, emergencies, flat tires, and bad weather do occur. We ask our patients to give us 48 hours' notice whenever possible, if they cannot keep an appointment. This allows us time to fill our schedule with other patients who may be waiting.

Failure to give 48 hour advance notice:

- No privilege of a Saturday appointment for future appointments, until 3 consecutive completed appointments

Definition of "Broken Appointment": A broken appointment is when you

- Cancel or reschedule an appointment with less than 48 hour notice
- Do not show up for the scheduled appointment

We strive to keep our office clean. Please have our star patients clean up after themselves in the play area.

I have reviewed, understand, and agree to comply with the above office policies.

______________________________	______________________________	______________________________
Signature of Patient or Legal Guardian	**Patient/Legal Guardian Name Printed**	**Childs Name**