PATIENT REGISTRATION

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ M.I. _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ SEX: _____ FEMALE _____ MALE DOB: _____

AGE: _____ PREFERRED NAME: _____ E-MAIL: _____

Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY FIRST NAME:

FIRST NAME: _____ LAST NAME: _____ M.I. _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

RELATIONSHIP TO INSURED: _____ BIRTH DATE: _____ SOCIAL SECURITY: _____

MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED IF DIVORCED, CHILD RESIDES WITH: _____

WHO HAS CUSTODY: _____ DO PARENTS AND CHILD LIVE TOGETHER: _____

IF NO, WHO HAS RESPONSIBILITY FOR MAKING DECISIONS ABOUT MEDICAL/DENTAL CARE: _____

PLEASE NOTE THAT THE PARENT WHO EXECUTES THIS DOCUMENT AND AUTHORIZES TREATMENT WILL BE CONSIDERED THE RESPONSIBLE PARTY FOR THIS CHILD'S FINANCIAL ACCOUNT

PRIMARY INSURANCE INFORMATION:

NAME OF POLICY HOLDER: _____ HOLDER'S SOCIAL SECURITY: _____

RELATIONSHIP TO PATIENT: _____ BIRTH DATE: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

ADDRESS: _____ ADDRESS: _____

CITY, STATE, ZIP CODE: _____ CITY, STATE, ZIP CODE: _____

SECONDARY INSURANCE INFORMATION:

NAME OF POLICY HOLDER: _____ HOLDER'S SOCIAL SECURITY: _____

RELATIONSHIP TO PATIENT: _____ BIRTH DATE: _____

EMPLOYER: _____ INSURANCE COMPANY: _____

ADDRESS: _____ ADDRESS: _____

CITY, STATE, ZIP CODE: _____ CITY, STATE, ZIP CODE: _____

CONSENT: The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents poses a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier. I also assign all dental insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account or refunded to me if requested. I understand that where appropriate, credit reports may be obtained.

PATIENT SIGNATURE (Parent of Child) _____ DATE: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Pediatrician's Name, Address, and Phone Number_____

_____.

Are you under a physician's care now?	◯ Yes ◯ No	If yes, please explain:	_____
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes, please explain:	_____
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes, please explain:	_____
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes, please explain:	_____
Are you on a special diet?	◯ Yes ◯ No		
Do you use controlled substances?	◯ Yes ◯ No		

Are you allergic to any of the following?

◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Acrylic ◯ Local Anesthetics ◯ Metal ◯ Latex ◯ Sulfa Drugs

◯ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

ADHD/ADD	Yes	No	Cortisone Medicine	Yes	No	Herpes	Yes	No	Sickle Cell Disease	Yes	No
AIDS/HIV Positive	Yes	No	Depression	Yes	No	High Blood Pressure	Yes	No	Sinus Trouble	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	High Cholesterol	Yes	No	Spina Bifida	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hives or Rash	Yes	No	Stomach/Intestinal Disease	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Hypoglycemia	Yes	No	Stroke	Yes	No
Angina	Yes	No	Emphysema	Yes	No	Irregular Heartbeat	Yes	No	Swelling of Limbs	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Kidney Problems	Yes	No	Thyroid Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Leukemia	Yes	No	Tonsillitis	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Liver Disease	Yes	No	Tuberculosis	Yes	No
Asperger's Syndrome	Yes	No	Fainting Spells/Dizziness	Yes	No	Low Blood Pressure	Yes	No	Tumors or Growths	Yes	No
Asthma	Yes	No	Frequent Cough	Yes	No	Lung Disease	Yes	No	Ulcers	Yes	No
Autism	Yes	No	Frequent Diarrhea	Yes	No	Mitral Valve Prolapse	Yes	No	Venereal Disease	Yes	No
Behavior Issues	Yes	No	Frequent Headaches	Yes	No	Osteoporosis	Yes	No	Yellow Jaundice	Yes	No
Blood Disease	Yes	No	Genital Herpes	Yes	No	Pain in Jaw Joints	Yes	No			
Blood Transfusion	Yes	No	Glaucoma	Yes	No	Parathyroid Disease	Yes	No			
Breathing Problem	Yes	No	Hay Fever	Yes	No	Psychiatric Care	Yes	No			
Bruise Easily	Yes	No	Heart Attack/Failure	Yes	No	Radiation Treatments	Yes	No			
Cancer	Yes	No	Heart Murmur	Yes	No	Recent Weight Loss	Yes	No			
Chemotherapy	Yes	No	Heart Pacemaker	Yes	No	Renal Dialysis	Yes	No			
Chest Pains	Yes	No	Heart Trouble/Disease	Yes	No	Rheumatic Fever	Yes	No			
Cold Sores/Fever Blisters	Yes	No	Hemophilia	Yes	No	Rheumatism	Yes	No			
Congenital Heart Disorder	Yes	No	Hepatitis A	Yes	No	Scarlet Fever	Yes	No			
Convulsions	Yes	No	Hepatitis B or C	Yes	No	Shingles	Yes	No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:_____

_____

_____

Comments: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Brunswick Pediatric Dentistry kidds
330-220-6363

OFFICE POLICIES & PROCEDURES

At Brunswick KiDDS, we strive to give patients access to the best dental care possible. The following policies and procedures have been implemented with your convenience and protection in mind.

- Financial Policy
- Insurance Policy/Services
- Broken Appointment Policy

FINANCIAL POLICY

Full Pay/Pre-Pay Courtesy:
A full/pre-payment courtesy of 5% will be subtracted from the total obligation if the entire treatment plan balance is paid in full with cash, check or money order 48 hours before the day of services or one (1) week before a scheduled surgery.
Credit Card: In order to facilitate access to the very best health care possible, you may choose from any of the following (including a combination thereof): VISA, MasterCard or Discover.
Half and Half: With this option, after an initial down-payment of 50%, you will make the second payment (balance) at time of treatment. Payments will be made through pre-authorized credit card charges or electronic fund transfers.
Third-Party Financing: With fast approval from a third-party finance company, your payments can be much lower than those available through our office. These companies specialize in helping patients obtain the treatment they need. We will help you process the necessary information.
If payment options other than "full/pre-payment" are chosen, we will require a credit card and signature to be kept on file (please fill out information on last page and return to front desk). If your account becomes delinquent, we reserve the right to apply the amount due to your credit card to satisfy the debt.
All credit card information will be securely stored electronically in your personal file (there will not be a paper trail) and can only be accessed by a password. Before an amount is charged to your credit card, you will be notified by phone.

INSURANCE POLICY/SERVICES

In an effort to help you understand your insurance policy and maximize your insurance benefits, we would like to share some facts about dental insurance with you.
Fact #1: Dental insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
Fact #2: Dental insurance does NOT usually cover all fees. It is meant to be an aid to your investment in your dental health care. There are a lot of dental services not covered by dental insurance.
Fact #3: Insurance companies will not release the exact amount they will pay for a procedure until the treatment is completed and the claim is submitted. They will only state the percentage of their fee schedule that they will cover.
We will file your insurance at no charge. In order to provide this service, we will need your updated and accurate insurance information before each appointment.
If after 45 days the insurance company has not paid, arrangements for your payment on the account must be made. You should contact your insurance company immediately regarding the non-payment of your claim.
If your account is not current after 60 days, the collection process will begin. All charges incurred in the recovery of a delinquent account will be the patient's responsibility. We regret when this action is necessary; however, we feel our office makes significant efforts to help our patients provide payment.
Any account that is overpaid will receive a prompt refund. Our office reserves the right to stop filing your insurance if, at any time, there is a problem with your account because of your carrier or an unwillingness to cooperate. It is your responsibility to give accurate insurance information so that filing the claims can be done in a timely manner.
Please do not hesitate to ask questions about our financial policy. We want you to understand and be comfortable with our policies. If you have any questions regarding your insurance, we ask that you contact your company regarding the specifics and details of your plan.

BROKEN APPOINTMENT POLICY

It is the responsibility of the parent to notify the dental staff at least 48 hours prior to their scheduled hygiene or restorative appointment time and at least 1 week prior to their scheduled surgery date if they will not be available for the appointment. Failure to do so could result in broken appointment fees ($50 hygiene, $50 restorative and $240 surgery).
Every effort will be made to contact patients two (2) days before their scheduled appointment to remind them of the time and provide any instructions prior to the appointment. The dental staff will make every effort to work with the patient to reschedule the appointment as soon as possible, if necessary. When the staff is expecting a patient, they routinely prepare the instruments and supplies for that patient's treatment. When the patient does not show up or is late, it results in wasted staff time, supplies and time that could have been used to see other patients. For this reason, we must enforce the following policy: **The parent of the patient will be charged $50.00 if more than ten minutes late for the appointment or if the appointment is broken. After three broken appointments, we will no longer schedule your child for services. Scheduled surgery appointments should be kept at any cost. Cancellations will result in your child's surgery not being rescheduled.**

By signing below, I acknowledge that I have read, understand and agree to the following policies (Financial Policy, Payment Options, Insurance Policy/Services, Broken Appointment Policy) outlined in the Office Policies and Procedures information I received.

Signature of Parent/Guardian _____ Date _____

Updated 4/12/18

Acknowledgement of Receipt of Notice of Privacy Practices

Brunswick KiDDS Dentistry

* You May Refuse to Sign This Acknowledgment*

I have received or been offered a copy of this practice's Notice of Privacy Practices.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

_____

Brunswick Pediatric Dentistry kidds
330-220-6363

Authorization For Use or Disclosure of Patient Information

BRUNSWICK KIDDS PEDIATRIC DENTISTRY

Patient Name_____ DOB_____

Patient Name_____ DOB_____

Patient Name_____ DOB_____

I hereby authorize the use and disclosure of the patient information as described below. 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.

Specific description of the patient information to be used or disclosed:

At the request of the parent or guardian for the purpose of dental examination, treatment, to receive home care instructions, and/or treatment recommendations. We may also notify your family or friends of your child/children's location and condition in the event of an emergency.

The following person(s) may receive this patient information:

Name_____Relationship_____

Name_____Relationship_____

Name _____Relationship_____

I understand that I may revoke this authorization at any time, and that my revocation is not effective unless it is in writing and received by the dental practice's Privacy Official at **Brunswick Kidds Pediatric Dentistry.** If I revoke this authorization, my revocation will not affect any actions taken by the dental practice before receiving my written revocation.

I understand that I may refuse to sign this authorization, and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility for benefits.

Signature of Parent or Legal Guardian:

_____Date_____

Print Name _____

Relationship to Patient _____