West Mobile CHILDREN'S Dentistry

Patient Registration and Health History

Patient's Name:_____ Preferred Name:_____

Date of Birth: _____ Gender:_____

Child's Home Address:_____

City:_____ State:_____ Zip Code:_____

School: _____ Grade:_____

Please list some of your child's interests:

_____

How did you hear about our office? _____

Family Information

Who has legal custody of the child? _____

Parent's Marital Status: Single ___Married ___Separated___Divorced___Widowed___

With whom does the child live?_____

List brothers/sisters with ages:_____

Signature of Parent/Guardian:_____ Date:_____

Guardian's Information

1) Name:_____ Relationship to patient:_____
Birthdate: _____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email:_____
Employer:_____

2) Name:_____ Relationship to patient:_____
Birthdate:_____
Address:_____
City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____
Work Phone:_____ Email:_____
Employer:_____

Responsible Party and Primary Dental Insurance

Person Responsible for Account and relationship to patient:_____

Insurance Company Name:_____

Policy ID:_____ Policy Group #:_____

Policy Holder's Birthdate:_____ Policy Holder's Social Security Number: _____

Policy Owner's Employer:_____

Secondary Dental insurance:_____

Signature:_____ Date:_____

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Health History

Is this your child's first dental visit? Yes__ No__ Last Visit Date:_____

At which office was your child previously seen?_____

How do you think your child will do at today's dental visit?_____

Has your child been to an orthodontist?_____

Do you have any concerns about your child's teeth?_____

Has your child had any injuries to the face, mouth, teeth or chin?_____

Has your child had any pain or tenderness in his/her jaw joints?_____

Does your child brush his or her teeth daily? Yes___ No___

Does your child floss his or her teeth daily? Yes___ No___

Is your home water supply city water or well water?_____

Does your child:

Suck a thumb or finger/fingers? Yes___ No___

Suck a pacifier? Yes___ No___

Use a bottle or nurse? Yes___ No ___

Who is your child's pediatrician?_____ Phone Number:_____

When was your child last seen by his/her pediatrician?_____

Signature:_____ Date:_____

Health History Continued

Please List all medications/ things your child is allergic to or write None:_____

Is your child taking any medications? If yes, Please list them

_____

Is your child allergic to: Latex…… Yes___ No___ Metals/Nickel….. Yes___ No___

Plastics….. Yes___ No___ Penicillin….. Yes___ No___

If Yes, What type of reaction?_____

Has your child ever had any of the following medical problems?

Y	**N**	Abnormal Bleeding	**Y**	**N**	Developmental Delay
Y	**N**	ADD/ADHD	**Y**	**N**	Diabetes
Y	**N**	Anxiety	**Y**	**N**	Down Syndrome
Y	**N**	Asthma	**Y**	**N**	Endocrine disorder
Y	**N**	Anemia	**Y**	**N**	Hearing Impairment
Y	**N**	Autism/Autism Spectrum	**Y**	**N**	Heart Murmur
Y	**N**	Disorder/Asperger's	**Y**	**N**	High Blood Pressure
Y	**N**	Behavioral disorders	**Y**	**N**	HIV/AIDS
Y	**N**	Bone/joint problems	**Y**	**N**	Hemophilia
Y	**N**	Cleft lip/palate	**Y**	**N**	Hepatitis
Y	**N**	Congenital Heart Defect	**Y**	**N**	Kidney Disorder
Y	**N**	Cancer	**Y**	**N**	Liver Disorder
Y	**N**	Depression	**Y**	**N**	Lupus
Y	**N**	Physical Handicap or Impairment	**Y**	**N**	Rheumatic/Scarlet Fever
Y	**N**	Seasonal Allergies	**Y**	**N**	Seizures/ Epilepsy
Y	**N**	Sensory disorder	**Y**	**N**	Sensory disorder
Y	**N**	Sickle Cell Disease/ Trait	**Y**	**N**	Tuberculosis
Y	**N**	Speech Impairment/Disability	**Y**	**N**	Vision Impairment
Y	**N**	Stomach/GI Disorders/ Acid Reflux			

Any Hospital Stays….. Yes___ No___ Reason: _____

Signature:_____ Date:_____

Acknowledgement of Access to Review Notice of Privacy Practices

I understand that I have had the opportunity to review a copy of the office's HIPAA Notice of Privacy Practices and have the ability to request a copy at any time. In addition, I realize that I am able to amend my privacy preferences at any time by written request.

_____ _____

Signature of Patient (Guardian) Date

West Mobile CHILDREN'S Dentistry

TO OUR PATIENTS WITH DENTAL INSURANCE

We are happy you have dental insurance to help you pay for dental services. You are fortunate to have it and we will go the extra mile to help you maximize your benefits provided by your specific plan. Your insurance company only pays a percentage of the fee, and this varies from plan to plan. 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.

PLEASE REMEMBER, HOWEVER, THE FINANCIAL OBLIGATION FOR DENTAL TREATMENT IS BETWEEN YOU AND THIS OFFICE, AND IS NOT BETWEEN US AND THE INSURANCE COMPANY.

If payment from you insurance company has not been received within 30 days of filing, we will re-file along with a "trace-letter". If after 45 days we still have not received a response from your insurance company, we may request your assistance in dealing with them. If after 90 days we have still not received payment, your account will become payable upon notice and any outstanding balance may be subject to a 1.5% per month (18% APR) service charge.

Thank you for your cooperation

I hereby authorize payment to West Mobile Children's Dentistry of the dental insurance benefits otherwise payable to me. I understand that I am personally responsible for all charges rendered regardless of insurance coverage.

FEDERAL AND STATE REGULATIONS REQUIRE THE FOLLOWING STATEMENT

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any and all collection agency fees, (33.33%), attorney fees and/or court costs, if such be necessary. I waive now and forever my right to exemption under the laws of the Constitution of The State of Alabama and any other state.

I agree, in order for us to service your account or to collect monies you may owe, West Mobile Children's Dentistry and or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I also understand that when appropriate, credit reports may be obtained.

I have read this and agree that West Mobile Children's Dentistry, and its employees and or agents may contact me as described above.

Signature _____ Date _____

Office Policy Regarding Appointments

It is the goal of our team to provide each of our patients with prompt and quality care. We understand that there are times when you must cancel an appointment due to emergencies or illness. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. **If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty dollar ($50) fee per patient appointment.** This will not be covered by your insurance company. **We may not be able to reappoint patients that do not cancel within 24 hours prior, no-show, or arrive late to their appointment.** Appointments are scheduled so that your child has a reserved time with Dr. Brooke and our hygienists and assistants. All appointments cancelled due to illness will be rescheduled a minimum of 2 weeks out. Thank you for your understanding and cooperation.

_____I have read this agreement and have a clear understanding of my responsibility to keep my family's appointments and arrive on time. If we cannot make an appointment, we will notify the office immediately. I understand that breaking appointments will result in a $50 fee per patient appointment, and may result in being unable to continue my child's care at West Mobile Children's Dentistry.

Patient Name:_____

Parent/Guardian Signature:_____ Date:_____

Proxy Form

Patient's Name: _____

Name of Person Completing this Form: _____

Relationship to the Patient: _____

If you don't want to authorize an additional person to make medical/dental treatment decisions & bring your child to his/her appointment, please write a check near the statement below.

_____ I don't authorize an additional person to make medical/dental treatment decisions or bring my child to his/her appointment.

If you would like for an additional person or people to make medical/dental treatment decisions & bring your child to an appointment please complete the rest of this form.

I authorize the following people to make medical/dental treatment decisions & bring my child to his/her appointments.

1) Person's full name:_____
   Person's relationship to child: _____
   Person's phone number:_____

2) Person's full name:_____
   Person's relationship to patient:_____
   Person's phone number:_____

Signature:_____

Date:_____

West Mobile CHILDREN'S Dentistry

Internet and Social Media Consent

Patient's Name:_____

Name of Person Signing this Form:_____

Relationship to Patient:_____

At West Mobile Children's Dentistry, we are proud of our patients and would love the opportunity to take pictures and share them on the Internet and Social Media websites such as Facebook and Instagram. Sharing pictures on these sites is a positive and great way for other children to see dentist as a fun and safe environment.

Please select on the following;

___ I do not consent to photographs being shared on the Internet and social Media sites.

___ I give full consent to the use of photographs on the Internet and Social Media sites

Signature of Parent/Guardian: _____

Date: _____