Patient Registration and History

Patient Information:

Name: _____

(Last) (First) (Middle) (Preferred name)

Age: Date of Birth: Gender:

Attends what school Grade List siblings and ages

****

II. Dental History

Is this your child's first dental visit? _____ Yes/ No
Name of previous dentist_____
Date of last visit to a dentist_____
For what service_____
Date of last cleaning_____
Reason for referral_____
Any oral habits – thumbsucking, nail biting, mouthbreathing, snoring, nursing or bottle habits, pacifier, etc. (circle/explain)?_____ Yes/No
_____
Has child complained about dental problems?____ Yes/No
Explain_____
Any unhappy dental experiences?_____ Yes/ No
Explain_____
Any injuries to mouth, teeth, or head?_____ Yes/No
Explain _____

At what age did your child's first tooth come in? _____
Any lost teeth? _____ Yes/No
Any oral surgeries? (i.e. frenectomy)_____Yes/No
_____
Orthodontic appliances worn now or previously?_____ Yes/No
Date: _____ Dentist/Orthodontist name?_____

How often are your child's teeth brushed?_____
Do you assist your child with tooth brushing?_____ Yes/No
Is dental floss used (how often)?_____ Yes/No

Is fluoride taken in any form?_____ Yes/No
Is your drinking water fluoridated?_____ Yes/No

Child's attitude toward dentistry (explain) _____
_____

III. Medical History

Physician's Name_____
Physician's Telephone #_____
Has your child had a physical exam in the last year? Yes/No
Is your child current on their immunizations? Yes/No
General Health: Excellent Good Fair Poor
Is your child taking any medications now (including Herbal or complimentary medicines?) Yes/No
Name of Medication _____
For what purpose? _____
Prescribed by whom? _____

Has your child ever been hospitalized? _____ Yes/No
_____
Has your child ever had surgery? _____ Yes/No
Allergy to penicillin or medications (list) _____ Yes/No
_____
Other allergies: food – pollen – animals – dust – latex – other (list) Yes/No
_____
Does your child have good physical coordination (explain)? _____ Yes/No
_____
Are there behavioral or developmental issues (explain)? _____Yes/No
_____

HAS CHILD HAD ANY HISTORY OF (OR DIFFICULTY WITH) ANY OF THE FOLLOWING:

___ADD
___Anemia
___Arthritis
___Asthma (Pulmonary)
___Autism/ASD
___Bladder
___Bleeding Disorder
___ Cerebral Palsy
___ Chronic Sinus
___ Craniofacial
___ Developmental Delays
___ Diabetes
___ Ears
___ Emotional/Mental Health
___Fainting
___Fever
___Gastrointestinal
___Hearing
___Heart
___Hepatitis
___Immunodeficiency
___ Jaundice
___ Kidney
___ Liver
___ Malignancies
___ Measles/Mumps
___ Mononucleosis
___ Orthopedic
___ Premature Birth
___ Rheumatic Fever
___ Seizures
___ Speech Therapy
___ Thyroid
___ Tuberculosis
___ Other

I understand that the information I provide on this form is essential to determine my child's dental treatment. I understand that if any change occurs in my child's health I am to report it to the dental office as soon as possible.

_____
Please Initial & Date

GENERAL INFORMATION

Guardian #1 information: Relationship to patient _____

Full Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone # (____) _____-_____ Work Phone # (____) _____-_____
Cell Phone # (____) _____-_____ E-mail address _____
Date of Birth _____
Social Security # _____-_____-_____
Place of Employment _____
Employment Address _____
Dental Insurance Carrier _____ ID #_____
Insurance Mailing Address _____
Insurance Co. Telephone # (____) _____-_____ Policyholder name _____

What is parents' marital status? Single/Married/Divorced/Widowed/Remarried/Domestic Partners

Guardian #2 information: Relationship to patient _____

Full Name _____
Address _____
City _____ State _____ Zip Code _____
Home Phone # (_____) _____-_____ Work Phone # (____) _____-_____
Cell Phone # (_____) _____-_____ E-mail address _____
Date of Birth _____
Social Security # _____-_____-_____
Place of Employment _____
Employment Address _____
Dental Insurance Carrier _____ ID # _____
Insurance Mailing Address _____
Insurance Co. Telephone # (_____) _____-_____ Policyholder name_____

☐ *I give Indianapolis Pediatric Dentistry permission to leave health information on my voicemail or answering machine.*

Person to contact in case of emergency if you cannot be reached:
Name _____ Home # (____) _____-_____ Work # (____) _____-_____
Name _____ Home # (____) _____-_____ Work # (____) _____-_____

How did you hear about our office? ☐ Dentist_____ ☐ Google ☐ Friend _____
☐ Physician _____ ☐ Facebook ☐ Other _____

CONSENT:

Your child is a minor; therefore, it is necessary that a signed permission be obtained from a parent or guardian before any dental services can be rendered. I grant Indianapolis Pediatric Dentistry permission to provide my child with dental care and I will be responsible for the total cost of the dental care.

Signature _____ Date _____

FINANCIAL POLICIES

Please read the following carefully before signing.

Indianapolis Pediatric Dentistry LLC is a participating provider with Delta Dental Premier, Anthem Dental Blue 100/200/300, and Dental Health Options. We accept all insurances; however, we are not "in-network" with all insurances.

1. Payment is due in full at the time services are rendered. As a courtesy, we will gladly file your insurance when you are able to provide all pertinent information. You are responsible for prompt payment of any balances remaining after insurance claims have been processed. A monthly finance fee (minimum of $6.00) will be applied to all accounts with an outstanding balance after 60 days.

2. We accept MasterCard, Visa, Discover, American Express and checks/cash. A $35.00 fee will be assessed to your account for any check returned for non-sufficient funds.

3. The responsible party is the parent that brings the child in for the dental visit, independent of what a divorce degree may state. Reimbursement must be made between the divorced parties. We will not intervene.

4. You agree to be financially responsible for all charges related to the services provided in our office, as well as any finance fees, collection agency costs, court costs and attorney fees for accounts that are not paid when due. Any accounts with balances that are 120 days past due may be forwarded to a third party collection agency.

Person Financially Responsible _____

Relationship to Child _____

Address _____

City _____ State _____ Zip Code _____

Home # (_____) _____-_____ Work # (_____) _____-_____

Appointment Cancellation Policies

Every effort is made to see patients in a timely manner and according to schedule. On time arrival for appointments helps us to provide the quality experience for which we strive. If you arrive 15 minutes or more after your appointment time, you may be asked to reschedule or wait until there is an opening, depending upon schedule and staff availability.

In order to meet the demands of the busy schedules of our patients, we offer to place patients on a waiting list. If you need to reschedule your appointment, advance notice is requested and appreciated so your appointment time can be offered to another patient.

Cancellation policy: Our office requires 48 hours notice of cancellation. For any appointment that is not cancelled 48 hours in advance, a fee of $50.00 per 30 minutes scheduled can be charged to your account. We reserve the right to dismiss a patient after the third failed appointment.

Signed_____ Date_____

(Parent or Guardian)

INDIANAPOLIS PEDIATRIC DENTISTRY
Dr. Erin F. Phillips & Dr. Kira Stockton
8433 Harcourt Road, Suite #307
Indianapolis, Indiana 46260
phone: 317-872-7272 fax: 317-872-0774

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____
_____
Address: _____
Telephone: _____

SECTION B: To the patient - Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Contact Person: Janet Alkire
Telephone: (317) 872-7272 Fax: (317) 872-0774
Address: 8433 Harcourt Road, Suite #307 Indianapolis, IN 46260

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____
Relationship to Patient: _____

Please list persons/parties of whom we may discuss your healthcare information with:
(i.e. grandparent, nanny, babysitter, step-parent, etc.)

_____ _____

_____ _____

Please list persons/parties of whom we are not to discuss your healthcare information with:

_____ _____ _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.