Patient Registration Form

Child's Information

Child's First Name: _____ Last Name: _____
Date of Birth: _____/_____/_____ Age: _____ Gender: ❑Male ❑Female
Address: _____
City: _____ State: _____ Zip: _____

Parent / Legal Guardian Information

First Name: _____ Last Name: _____
Cell #: _____ Work #: _____
Email Address: _____

Emergency Contact Name: _____ **Relationship**: _____
Phone #: _____

If anyone other than above will bring the child to their dental appointment, please include their name below. Please note – child will NOT be seen if name is not included here unless a notarized form is provided from parent/Legal guardian!!

Name: _____ Relationship: _____

Medical History

Name of Pediatrician _____ Phone #: _____
Date of last physical exam: _____ Is Patient in good health ❑Yes ❑No Weight: _____ lb
Any history of major illness? ❑Yes ❑No Explain? _____
Ever been hospitalized? ❑Yes ❑No If yes for what condition? _____

Please check box ☑ if patient has or ever has had one of the following conditions:

❑ ADHD	❑ Cystic Fibrosis	❑ Fainting/Dizziness	❑ Nutritional Disorder
❑ Asthma	❑ Diabetes	❑ Hearing Disorders	❑ Prolonged Bleeding
❑ Autistic	❑ Developmental Delay	❑ Heart Disease/Murmur	❑ Rheumatic Fever
❑ Blood Disorders	❑ Downs Syndrome	❑ Hepatitis	❑ Sickle Cell Disease
❑ Bone Disorders	❑ Ear Infections	❑ HIV / AIDS	❑ Speech disorders
❑ Cancer	❑ Epilepsy/Seizures	❑ Liver /Kidney Disorders	❑ Tuberculosis
❑ Cerebral Palsy	❑ Endocrine Disorders	❑ Mental Disorders	❑ Thyroid Issues

❑ Other _____
Please specify if checked yes _____

My child does not have any of the above health conditions ❑

Does Patient need antibiotics prophylaxis prior to dental treatment? ❑Yes ❑No

Does Patient have allergies? ❑Yes ❑No

Penicillin or any other antibiotic ❑Yes ❑No
Latex ❑Yes ❑No
Local Anesthetic ❑Yes ❑No
Other: _____

Taking any medications? ❑Yes ❑No

What medications? _____
_____
_____

Dental History

Date of Last Dental Visit:_____
Does child brush twice a day? ❑Yes ❑No
Is child using Fluoride toothpaste? ❑Yes ❑No
History of thumb, finger or pacifier habit? ❑Yes ❑No
Any injuries to the mouth, head or teeth? ❑Yes ❑No If yes explain: _____
Previous dental radiographs (x-rays)? ❑Yes ❑No
Does your child grind their teeth? ❑Yes ❑No

Authorization and Release

I certify the above information to be true to the best of my knowledge. I also understand that providing incorrect information is dangerous and I agree to inform the office of any changes in my child's health. I authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, administration of local anesthetic and fluoride which have been deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

I certify that my child is covered by dental insurance. I understand that Sunkidz Pediatric Dentistry Group will file the claim for dental treatment completed on my child on my behalf. I acknowledge that I will be financially responsible for dental treatment not covered by my childs insurance.

Signature: _____ Relationship _____ Date _____

Consent for Photographs

At Sunkidz Pediatric Dentistry we sometimes like to take photographs of our patients to document the children during their dental visit! From time to time we use these photos for publicity, educational, marketing and advertising. All promotional photos and materials will be viewed and approved before they are used in any manner. Please circle **Yes** or **No** below
Yes, I give my consent for photographs of my child to be used
No, I do not give consent for photographs of my child to be used
Parents Name: _____
Signature: _____
Date: _____
Child's Name: _____

Acknowledgment of Receipt of Notice of Privacy Practices

Sunkidz Pediatric Dentistry Group, LLC has a detailed document called 'Notice of Privacy Practices'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Sunkidz Pediatric Dentistry Group, LLC will provide me with the most current NOTICE OF PRIVACY PRACTICES.

I understand that Sunkidz Pediatric Dentistry Group, LLC may use or disclose my protected health information for treatment, payment or health care operations – which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

My signature below indicates that I have been given the chance to review such a copy of the NOTICE OF PRIVACY PRACTICES. My signature means that I agree to allow Sunkidz Pediatric Dentistry Group, LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Sunkidz Pediatric Dentistry Group, LLC has taken action relying on this consent.

It is your right to refuse to sign this acknowledgement form!

_____	_____	_____
SIGNATURE OF PARENT / LEGAL GUARDIAN	**PRINT NAME**	**DATE**

You may obtain a copy of our NOTICE OF PRIVACY PRACTICES, including any revisions of our 'Notice' at any time. Please ask us for a copy.

DENTAL OFFICE USE ONLY

I tried to obtain written acknowledgment by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ The Individual was unwilling to sign.
- ❑ A communication barrier prevented us from obtaining acknowledgement.
- ❑ An emergency prevented us from obtaining acknowledgment.

_____	_____	_____
PRINT EMPLOYEE NAME	**EMPLOYEE SIGNATURE**	**DATE**

Informed Consent

Please read this form *carefully!* If you do not understand something to your satisfaction, please ask questions. We will be happy to explain it!

1. I request and authorize the treatment and procedures for my child.
2. I further request and authorize the taking of dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s).
3. I have had explained to me by Dr. Patel and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.
4. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.
5. I **understand** that during the course of the patient's treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's PLAN OF CARE and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives at Sunkidz Pediatric Dentistry
6. I **understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.
7. I **understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and /or legs, dental treatment cannot be **safely** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient hands, stabilize the head and/or control leg movements.
8. I **further understand** that should the patient become uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in a "hug blanket" or "papoose board" to prevent injury and enable Dr Patel to ***safely*** provide the necessary treatment. A separate consent form will be used should this procedure be necessary, and you would be notified prior.
9. For the purpose of advancing medical-dental education, I give permission for the use of clinical dental photographs of the patient for diagnostic, scientific, educational or research purposes.
10. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient.
11. I **understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
12. I **confirm** that I read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

_____

Patients Name

_____

Parents Name / Signature / Date