

**PEDIATRIC  
VERSION**  
patients under 18



## New Patient Registration Form

### PATIENT INFORMATION

<b>Last name:</b>		<b>First Name:</b>		<b>Middle Initial:</b>
<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____		<b>Social Security #:</b>	<b>Birth Date:</b>	<b>Sex:</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>Street Address:</b>		<b>City:</b>	<b>State/Zip Code:</b>	
<b>Email address:</b>				
<b>Cell Phone:</b>	<b>Home Phone:</b>	<b>Work Phone:</b>		
			<b>Ext:</b>	
<b>Primary Care Physician Name:</b>	<b>Physician Address:</b>		<b>Physician Phone:</b>	
<b>Employer Name:</b>	<b>Employer Address:</b>		<b>Occupation:</b>	
<b>Pharmacy Name:</b>	<b>Pharmacy Address:</b>		<b>Pharmacy Phone:</b>	

I give **WestDental** consent to communicate with the following individual(s) about my healthcare Including but not limited to appointment details and treatment plans;

<b>Name:</b>	<b>Relationship to Patient:</b>
--------------	---------------------------------

### PARENT/ GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

 Not Applicable

<b>Custodial Parent/ Guardian Name (s):</b>	<b>Phone Number:</b>
<b>Address:</b>	
<b>Custodial Parent/ Guardian Name (s):</b>	<b>Phone Number:</b>
<b>Address:</b>	

### CAREGIVER INFORMATION (IF APPLICABLE)

 Not Applicable

In the case that no parent/guardian can be reached, please allow the following named individual to consent to Dental Treatment for the above-named child in accordance with **WestDental** Policy:

1. Parent/Guardian must be present and consent for new Dental Treatment.
2. Caregiver may bring child in for pre-determined treatment discussed with parent and hygiene exam.
3. Unexpected treatment discovered when caregiver is present requires oral consent of the parent/guardian which office staff must obtain and record in chart.
4. I allow my child to receive x-rays under his/her supervision.  Yes  No

<b>Caregiver's Full Legal Name:</b>	<b>Date of Birth:</b>
<b>Address:</b>	<b>Phone Number:</b>

**Relationship to Child:**

## Pediatric Health History Form

(1 of 2)

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ SS #: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: \_\_\_ Male \_\_\_ Female Pronouns: \_\_\_\_\_

Parent #1: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Parent #2: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Work#: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

Have we seen other children in your family? \_\_\_\_\_

### MEDICAL HISTORY

Child's Physician/ Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Is your child in good health? Date of last physical exam: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Has your child ever had a health problem? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Is your child allergic to anything? \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Are your child's immunizations/ vaccines up to date? If not, please explain: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Has your child had any surgeries/ hospitalizations? If yes, please explain: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Is your child currently taking any medications? Please give medications, dosage, and reason: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Has your child ever had a blood transfusion

\_\_\_ Yes \_\_\_ No Does your child smoke or use tobacco products?

\_\_\_ Yes \_\_\_ No Has your child previously seen a dentist?

Date last seen: \_\_\_\_\_ Name of Dentist: \_\_\_\_\_

\_\_\_ Yes \_\_\_ No Has your child ever received fluoride in any form?

\_\_\_ Yes \_\_\_ No Does your child suck his/her thumb or fingers?

\_\_\_ Yes \_\_\_ No Are your child's teeth brushed once or more a day?

\_\_\_ Yes \_\_\_ No At what age did your child stop bottle/breast feeding? \_\_\_\_\_

# Pediatric Health History Form

(2 of 2)

**Please check any of the following which your child has been treated for:**

- |   |   |  |  |  |
|---|---|--|--|--|
| <input type="checkbox"/> Aids             | <input type="checkbox"/> Cleft Lip/Palate         | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Pregnant            | <input type="checkbox"/> Spinal Bifida   |
| <input type="checkbox"/> ADHD             | <input type="checkbox"/> Congenital Birth Defects | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Syndrome        |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Seasonal Allergies  | <input type="checkbox"/> Tonsils/Adenoid |
| <input type="checkbox"/> Asthma/Breathing | <input type="checkbox"/> Endocrine/Growth         | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Autism           | <input type="checkbox"/> Eyesight                 | <input type="checkbox"/> Latex Allergy       | <input type="checkbox"/> Shunt               |  |
| <input type="checkbox"/> Blood Dyscrasias | <input type="checkbox"/> Food Allergies           | <input type="checkbox"/> Liver/GI Disease    | <input type="checkbox"/> Sickle Cell Disease |  |
| <input type="checkbox"/> Cancer/Tumors    | <input type="checkbox"/> Frequent Infections      | <input type="checkbox"/> Mental Delays       | <input type="checkbox"/> Snoring             |  |
| <input type="checkbox"/> Cerebral Palsy   | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Personality/ Social | <input type="checkbox"/> Speech/Hearing      |  |
- Other: \_\_\_\_\_

- |                |   |
|----------------|---|
| ___ Yes ___ No | Does your child snore?  |
| ___ Yes ___ No | Does your child wake up with headaches in the morning?  |
| ___ Yes ___ No | Does your child seem sleepy during the day?   |
| ___ Yes ___ No | Has your child ever woken gasping for air?  |
| ___ Yes ___ No | Has anyone in your family been diagnosed with sleep apnea? If yes, what treatment was received? _____ |

Is there anything else we should know about your child?

\_\_\_\_\_  
\_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

## Responsible Party and Insurance Info

RESPONSIBLE PARTY INFORMATION				
The following is for: <input type="checkbox"/> Patient <input type="checkbox"/> Person Responsible for Payment <input type="checkbox"/> Relationship to Patient _____				
Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Other _____	
SS#:	Birth Date:	Home Phone:	Work Phone:	Cell Phone:
Street Address:			City/State/Zip:	
INSURANCE INFORMATION				
<b>PRIMARY INSURANCE:</b>				
Occupation:	Employer:	Employer Address:		Employer Phone:
Name of Primary Insurance:				
Subscriber's Name:		Birth Date:	Group #:	ID #:
Patient's Relationship to Subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____		
<b>SECONDARY INSURANCE:</b>				
Occupation:	Employer:	Employer Address:		Employer Phone:
Name of Secondary Insurance:				
Subscriber's Name:		Birth Date:	Group #:	ID #:
Patient's Relationship to Subscriber:		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____		

### Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign all insurance benefits directly to **WestDental** that are otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits and authorize the use of this signature on all insurance submissions.

\_\_\_\_\_  
Patient/Guardian Name (Print):

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Patient/Guardian Name (Signature):

\_\_\_\_\_  
Date:

## Consent for Dental Treatment and Acknowledgement of Receipt of Information

State law requires our office to obtain your consent for your contemplated oral care and dental treatment. Please read this form carefully and ask about anything you do not understand. We will be pleased to further explain and discuss your concerns and questions.

I hereby authorize consent for oral and dental treatment that may include, but not limited to, the following: examination, radiographs (x-rays), diagnosis, dental prophylaxis (cleaning), fluoride treatment, restorations (i.e. fillings, pulpotomy, stainless steel crowns), anesthesia, oral surgery (extractions), interceptive orthodontic treatment and emergency treatment.

I understand that during any planned procedure, unforeseen conditions may arise that may necessitate treatment or procedures in addition to, or different from those originally discussed. In addition, although I am not advised that positive results are expected, the possibility and nature of complications cannot be accurately anticipated and, therefore, there can be no guarantee expressed or implied either as to the result of treatment.

Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. These risks include, but are not limited to the following: nausea following anesthesia, numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of various materials (i.e. stainless-steel crowns), injury to the tongue, lips, cheeks, damage to possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. I further understand and accept that complication may require additional medical, dental or surgical treatment and may require hospitalization.

### **Understanding this Form**

I hereby state that I have read and understand this consent form, that I have been given the opportunity to ask questions that I might have and that all questions have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions that may arise during the course of my treatment.

I further understand that I am free to withdraw my consent to treatment at any time, and that my consent will remain in effect until such time that I choose to withdraw it.

\_\_\_\_\_  
Patient/Guardian Name (Print):

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Patient/Guardian Name (Signature):

\_\_\_\_\_  
Date:

## Referral Information

**Tell us how you learned about our practice.**

Please choose one blue box and then select one of the choices within that box.

01	<b>Neighborhood:</b>	<b>Select one:</b> Neighborhood • Saw Sign • Walk In
02	<b>Insurance Company:</b>	<hr style="border: 0; border-top: 1px solid black;"/> <div style="text-align: center; font-size: small;"><i>Company Name</i></div>
03	<b>Family / Friend:</b>	<hr style="border: 0; border-top: 1px solid black;"/> <div style="text-align: center; font-size: small;"><i>Name of Family Member or Friend</i></div>
04	<b>Online:</b>	<b>Select one:</b> Internet Search • Social Media • Website
05	<b>Advertisement:</b>	<b>Select one:</b> Flyer/Postcard • Magazine • Mailing • Newspaper Outdoor/Community • Television
06	<b>Event:</b>	<hr style="border: 0; border-top: 1px solid black;"/> <div style="text-align: center; font-size: small;"><i>Event Name</i></div>
07	<b>Dentist:</b>	<hr style="border: 0; border-top: 1px solid black;"/> <div style="text-align: center; font-size: small;"><i>Dentist Name</i></div>
08	<b>Employee:</b>	<b>Select one:</b> Our Company • CareMount • Catholic Health • Mt. Sinai Optum • ProHEALTH • Riverside • WestMed • Other
09	<b>Other:</b>	<hr style="border: 0; border-top: 1px solid black;"/> <div style="text-align: center; font-size: small;"><i>Description</i></div>
99	<b>Doctor / Medical Office:</b>	<b>Select one:</b> CareMount • Catholic Health • Mt. Sinai Optum • ProHEALTH • Riverside • WestMed • Other  <hr style="border: 0; border-top: 1px solid black;"/> <div style="text-align: center; font-size: small;"><i>Doctors Name</i></div>

## Financial Agreement

Our goal is to provide the highest quality of dental care possible as well as a positive patient experience. Please see our financial policy.

**All accounts are due and payable at time of service.**

If a procedure requires multiple appointments, payment may be paid with a minimum of two payments or based on the number of appointments to complete treatment.

**Payment Options:**

- Cash
- Check
- Visa / MasterCard / Discover / AMEX
- The Lending Club / Care Credit

**Patients with Insurance:** The patient/guarantor is responsible for the **estimated** non-covered portion, procedures and/or deductibles at the time of the service. Due to insurance policy changes and/or necessary changes in treatment plans, the insurance coverage may vary from the estimated treatment calculation. I acknowledge this is an estimate only and that I, not the insurance company, am ultimately responsible for payment in full for all services not covered for any reason by my insurance.

**Parents not accompanying their child** to an appointment must make **prior** arrangements for payment (cash, check or credit card authorization). **Parents accompanying their children** are financially responsible for payment.

There is a processing charge for **non-sufficient funds** or returned checks.

As instruments, chairs and personnel are reserved exclusively for your appointment, there may be a fee charged for changed or broken appointment with less than 24 hours in advance.

\_\_\_\_\_  
Patient/Guardian Name (Print):

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Patient/Guardian Name (Signature):

\_\_\_\_\_  
Date:

## Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the *Health Insurance Portability & Accountability Act of 1996 (HIPAA)*. I understand that this information can and *will* be used to:

- Provide and coordinate my treatment among many health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

\_\_\_\_\_  
Patient/Guardian Name (Print):

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Patient/Guardian Name (Signature):

\_\_\_\_\_  
Date: