New Patient Registration Packet

Welcome to Jack and Jill Pediatric Dentistry!

Thank you for choosing our office for your dental needs. We look forward to meeting and working with you! Jack and Jill Pediatric Dentistry is a professional and comprehensive pediatric dental care practice focused on building a foundation of trust by treating our patients of all ages with the utmost care. Our commitment is to ensure that you and your family feel welcomed, informed, and comfortable. Our key philosophy is prevention, and our team works hard to provide state of the art treatment, while taking the time to educate our patients about preventive care.

This initial registration packet is for us to get to know you, to help address your concerns/needs, get you processed into our system, and then continue on with the dental treatment and services as needed. If you have any questions please feel free to ask our front desk staff. We will be happy to help you!

Patient Information:

First Name: Last Name: Sex: ☐ M ☐ F

Date of Birth (DOB): Age:

Responsible Party: ☐ Self ☐ Parent/Guardian

First Name: Last Name: DOB:

Address: City:

State: Zip Code:

Home Phone: Cell/Work Phone:

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

☐ Email: ☐ Phone ☐ Text

☐ By checking this box, I consent to the following: The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

Responsible Party Signature:_____ Date:_____

Primary Insurance Policy:

Primary Insurance: Policy ID #:

Policy Holder's Name: Policy Holder's DOB:

Patient's Relationship to Policy Holder:

Secondary Insurance Policy:

Secondary Insurance: Policy ID #:

Policy Holder's Name: Policy Holder's DOB:

Patient's Relationship to Policy Holder:

Pediatric Medical History:

Patient Name:_____ Date of Birth:_____

Is your child under the care of a physician now? ☐ Yes ☐ No

If yes, please explain:

Does your child have any allergies (i.e., food, medication, etc.)? ☐ Yes ☐ No

If yes, please, explain:

Is there any family history of allergies to medications? ☐ Yes ☐ No

If yes, please explain:

Is your child taking any medications including over the counter medication? ☐ Yes ☐ No

If yes, please explain:

Is your child's immunization current? ☐ Yes ☐ No

Is your child taking antibiotics before having dental treatment? ☐ Yes ☐ No

Has your child had any serious illness? ☐ Yes ☐ No

Has your child ever been hospitalized or an emergency room visit? ☐ Yes ☐ No

If yes, please explain:

Does your child have any habits (i.e., thumb sucking, bottle, pacifier, etc.)? ☐ Yes ☐ No

If yes, please explain:

Please check if your child has a history of or has been treated for any of the following:

☐ Abuse	☐ Congenital Birth Defects	☐ Physical Delay
☐ ADD/ADHD	☐ Diabetes	☐ Recurrent Headaches
☐ Adverse Drug Reaction	☐ Emotional Problems	☐ Rheumatic Fever
☐ Anemia	☐ Endocrine Problems	☐ Seizures
☐ Arthritis	☐ Frequent Infection	☐ Sickle Cell Disease
☐ Asthma	☐ Heart Disease	☐ Speech/Hearing
☐ Autism	☐ Heart Murmur	☐ Down Syndrome
☐ Bleeding/Transfusion	☐ Hepatitis	☐ Spina Bifida
☐ Blood Dycrasias	☐ HIV/AIDS	☐ TB
☐ Cancer	☐ Kidney Disease	☐ Tonsil/Adenoid Problems
☐ Cerebral Palsy	☐ Liver/GI Disease	☐ Vision Problems
☐ Cleft/Lip Palate	☐ Mental Delay	☐ Other:

Additional comments/illness not listed above:

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 child's) health. It is my responsibility to inform the dental office of any changes in medical history.

Responsible Party Signature:_____ Date:_____

Informed Consent for Dental Treatment and Procedures

1. You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consent to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

X-rays: *Proposed treatment: taking of intraoral and extraoral radiographs. Benefits of treatment: taking x-rays enables us to view dental cavities, abnormalities, development and eruption of teeth. They are necessary for proper diagnosis and evaluation purposes. Alternative treatment: none; limited visual examination. Consequences of not performing: missed diagnosis. Common risk: Radiation exposure to soft and hard tissue.*

Responsible Party Initial: _____

Cleaning: *Proposed treatment: involves thorough cleaning of teeth to help heal inflamed or infected gum tissue. It involves removal of soft plaque build-up and harder calculus deposits above and below the gum line. Benefit of treatment: healthy oral environment; also reduction/elimination of bleeding, odor, and periodontal disease. Alternative treatment: referrals for periodontal surgery according to the severity of condition. Consequences for not performing: discontinued or interrupted treatment could result into further inflammation and infection of gum tissues; lead to more tooth decay, and deterioration of surrounding bone structure which could lead to tooth loss. Common risk: bleeding, soreness, swelling, infection of tissue, hot and cold sensitivity, stiff or sore jaw joint.* ***Responsible Party Initial:*** _____

2. Drugs and Medication

I understand that antibiotics, analgesics, and other medication can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). ***Responsible Party Initial:*** _____

3. Change of Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I understand that changes will be discussed prior to treatment and I give permission to the dentist to propose any/all changes and additions as necessary. I understand that any changes may affect my copayment for services rendered.

Responsible Party Initial: _____

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. ***Responsible Party Initial:*** _____

Patient Name (Please Print):_____

Responsible Party Signature:_____ Date:_____

Patient Name (Please Print):_____

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices ("Acknowledgement")

By signing below, I acknowledge that I have received a copy of Jack and Jill Pediatric Dentistry's HIPAA Notice of Privacy Practices.

Personal Representative Signature:_____ Date:_____

Authority of Personal Representative to Sign for Patient (Please Check One):

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other:

***Please Note: It is your right to refuse to sign this acknowledgement.**

Dental Office Use Only:

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

☐ An emergency prevented us from obtaining acknowledgement
☐ A communication barrier prevented us from obtaining acknowledgement
☐ The individual was unwilling to sign the acknowledgement
☐ Other:

Staff Member Signature:_____ Date:_____

Acknowledgment of Receipt of Office Policy

By signing below, I acknowledge that I have received a copy of Jack and Jill Pediatric Dentistry's Office Policy.

In addition, I agree to the terms of the financial agreement and agree to pay for all services that are received.

Responsible Party Signature:_____ Date:_____