We Care for Kids Dental
General Dentistry for Children and Young Adults
Leslie A. Olton, DMD Deborah Fuller, DMD, MS

PATIENT REGISTRATION FORM

Please Print Date:

Who can we thank for referring you to our office? _____

Patient Name_____
(First) (Middle) (Last)

Preferred Name (if applicable)_____ DOB_____ Sex: Male Female

Patients Address _____ Contact Phone # _____

_____

Mothers Name _____ DOB _____

Fathers Name _____ DOB _____

Parents Marital Status _____ Address (if different from above) _____

Father's Employer _____ SS# _____ Phone # _____

_____

Mother's Employer _____ SS# _____ Phone # _____

_____

FOR PATIENTS COVERED BY INSURANCE

Subscribers Name_____DOB_____SS#_____

Subscribers Employer_____Address_____

Dental Insurance Company_____

Group #_____ Subscriber ID #_____

SECONDARY INSURANCE (if applicable)

Subscribers Name_____DOB_____SS#_____

Subscribers Employer_____Address_____

Dental Insurance Company_____

Group #_____ Subscriber ID #_____

Are there other children in your family?

Name(s): _____ Age: _____ Name(s): _____ Age: _____

_____ Age: _____ _____ Age: _____

_____ Age: _____ _____ Age: _____

HEALTH HISTORY

Childs Physician: _____ Phone: _____

Address: _____

Date of last physical exam _____

	Yes	No
Is your child under care of a physician/doctor/dentist? Please Explain	☐	☐
Is your child under the care of a psychiatrist/psychologist for any mental or emotional issues? Please Explain	☐	☐
Has your child ever been hospitalized? Please Explain	☐	☐
Is there any excessive bleeding when cut?	☐	☐

Has your Child had any history or difficulty with the following (please circle)

Anemia	Asthma	Cerebral Palsy	Chronic Sinus	Blood/Bleeding Disorders	Learning Disability
Convulsions	Diabetes	Epilepsy/Seizures	Fainting	Bone/Joint Replacement	Speech Problems
Hearing	Heart	Hepatitis	HIV/AIDS	Ear Aches/Infections	Tobacco Use (Teen)
Liver	Poor Vision	Pregnancy (teen)	Rheumatic Fever	Mononucleosis	Thyroid
		Cancer	Kidney	Tuberculosis	Genetic Testing

Has your child been tested for any problem or condition not metioned above? _____

Please describe any current medical treatment, pending surgery, recent injuries or any other information we should be aware of _____

HEART MURMUR

	Yes	No
Has your child ever been diagnosed with a heart murmur?	☐	☐
If yes, have you been instructed to take antibiotic prophylaxis prior to dental treatment?	☐	☐

***If your child has been diagnosed with a Heart Murmur but does not required antibiotics, our practice REQUIRES documentation from the child's physician stating Antibiotic Prophylaxis is not necessary.**

ALLERGIES & MEDICATIONS

Has your child had an allergic reaction to medications or food? i.e. Amoxicillin, sulfur drugs, asprin, local anesthetics, latex, nuts, fruits, etc. YES NO (circle one)

Allergy To:	Reaction Type:	Treatment:

Is your child currently taking any medication(s)? (including prescription and over-the-counter medications) YES NO (circle one)

Medication:	Dose:	Frequency:

Pharmacy:	Phone:	Address:

Parent Signature:

Print _____ Sign _____ Date _____

DENTAL HISTORY

Is this your childs first visit to the dentist? YES NO

Date of last dental visit: _____

For what service (cleaning, emergency visit, filling) _____

Date of last x-rays: _____

	Yes	No		Yes	No
Does your child brush their teeth daily?	☐	☐	Do you assist your child with brushing?	☐	☐
Any injuries to mouth, head, or teeth? _____	☐	☐	Is dental floss used/how often? _____	☐	☐
			Does your child take any fluoride supplements?	☐	☐
Has your child complained about dental problems? Explain	☐	☐			
			Orthodontic appliances, worn now or in the past?	☐	☐
Any unhappy experiences? Explain _____	☐	☐			
			How would you describe your child? Shy		Frightened
Any dental habits - thumb sucking, pacifier, etc _____	☐	☐	Apprehensive		Confident

ADDITIONAL INFORMATION

How does your child react to their physician? _____

How does your child react to having his/her haircut? _____

School Information:

School Name _____ Teacher _____ Grade _____

Does your child have any interests or hobbies? _____

Does your child have any distinguishing marks (including birthmarks, scars, or tattoos) on any part of the body? _____

Is there any additional information that you think might be useful in treating your child?

* Required

SIGNATURE AUTHORIZATION FOR INSURANCE & OFFICE POLICIES

I hereby authorize my insurance company to pay Leslie A. Olton, DMD or Deborah Fuller, DMD for all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. **I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment service charges, including returned check fees. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of We Care for Kids Dental, Inc**. This consent is to remain in effect from the date indicated until cancelled in writing.

OUR CANCELLATION POLICY

There will be a $50 charge for all missed appointments as well as any appointments cancelled without 24 hours notice from your scheduled time. We make every effort possible to remind you of the time you have reserved with our practice. When you schedule your appointment in the office, you are offered an appointment card. We mail or email a reminder notice 1 month ahead of your appointment. We then call 2 days before your appointment and leave a message on the answering machine or service, or give the message to the person answering the phone. We do all of this as a courtesy and to help reduce missed appointments. In missing the appointment, not only does your child not receive dental treatment, but it unfairly denies time to other children in need of dental care. When given sufficient notice of a cancellation we may be able to offer your child's appointment time to another child.

In short, we would rather not charge you for missed or cancelled appointments; we simply want you to show up for the time we reserved especially for you.

Signature: _____ Date: _____

*Required

HIPAA

Receipt of the Notice of Privacy Practices

Patients Name: _____

Date Notice was effective: September 23, 2013

I have reviewed this office's Notice of Privacy Practices. I am aware that a copy of this Notice is available for review on the company website at www.WeCareForKidsDental.com, as well as posted in the waiting room.
You have the right to a paper copy of this Notice. If you wish to obtain a paper copy, please request a copy from the front desk.

Full Name & Relationship of Personal Representative to Patient:

Print Name/Relationship: _____

Signature: _____ Date: _____

If you would like a copy of the HIPAA Act, we have copies available on our website as well as at the front desk at your request

*Optional

FACEBOOK & WEBSITE PHOTOS

To keep up with the times, We Care for Kids Dental has created a Facebook page & website. With your permission, we may like to feature your child's smile on these sites. For your comfort, if a picture is taken of your child at the time of their appointment, we will double check with you for your permission to post the photo. If you are not present at the time of your child's appointment, no pictures will be posted.

I hereby authorize photos taken of my child at the time of their appointment to be posted on the We Care for Kids Dental website and/or Facebook Page.

Signature: _____ Date: _____

*Optional

EMAIL

In an effort to improve communications with our patients, We Care for Kids Dental, Inc. is able to email appointment reminders. If you are interested in being a part of this service, please enter your information below. Please be aware that this email address may also be used to email you personal information (i.e. Receipts, Letters) relating to your dental care. Your information is used only for communications with you and other dental professionals. We do NOT share or sell personal information.

Personal Email: _____

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Consent for Fluoride Treatment

Fluoride is effective in preventing and reversing the early signs of dental caries (tooth decay). Research has shown that there are several ways through which fluoride achieves its decay-preventive effects. It makes the tooth structure stronger, so teeth are more resistant to acid attacks. Fluoride also acts to repair, or remineralize, areas in which acid attacks have already begun. The remineralization effect of fluoride is important because it reverses the early decay process as well as creating a tooth surface that is more resistant to decay.

Coverage for Fluoride treatment can vary between once or twice a year, depending on your dental insurance plan. Please contact your dental insurance company for coverage questions.

Patient's name: _____ DOB _____

Please choose one of the following options:

___ I give my consent to apply Fluoride treatment **twice a year**. I agree that if my insurance company does not pay for the second application that I am responsible for payment.

___ I give my consent to apply Fluoride treatment **only once a year**.

___ I **do not wish** Fluoride treatment to be applied to my child at any time.

Signature Relationship to patient Date

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