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# Patient Registration Form

## Tell us About your Child

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_  Male  Female  
Child's Date of Birth: \_\_\_\_\_ Child's Age: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Child's Home Phone Number: \_\_\_\_\_

## Who is Accompanying the Child Today?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Do you have legal custody of the child?  Yes  No  
In case of an emergency, contact (name **and phone #**): \_\_\_\_\_ relationship: \_\_\_\_\_  
Whom may we thank for this referral? \_\_\_\_\_

## Person Responsible for Account

### Mother's Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employed by: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Business phone #: \_\_\_\_\_  
Home phone #: \_\_\_\_\_ cell: \_\_\_\_\_  
email address: \_\_\_\_\_

### Father's Information:

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Address: \_\_\_\_\_  
Employed by: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Business phone #: \_\_\_\_\_  
Home phone #: \_\_\_\_\_ cell: \_\_\_\_\_  
email address: \_\_\_\_\_

## Dental Insurance

Insurance Co. Name: \_\_\_\_\_  
Insurance Co. Address: \_\_\_\_\_  
Insurance Co. Phone #: \_\_\_\_\_ Group # (plan, local or policy #): \_\_\_\_\_  
Insured's Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_  
Insured's Employer: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ SS#: \_\_\_\_\_

## Authorization

I certify the truth of all information provided. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Kailes, otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual amount billed for services and may not cover all services provided.** I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_

COMMENTS  
(for office use only)

Dr. Initials

**MEDICAL HISTORY:**

- 1. Name of pediatrician \_\_\_\_\_ Phone No. \_\_\_\_\_
- 2. Is your child under the care of another physician/specialist?.....  Yes  No  
If yes, since when and why? \_\_\_\_\_
- 3. Is your child receiving any medication?.....  Yes  No  
List current medications \_\_\_\_\_
- 4. Is your child allergic to any drugs, such as penicillin?.....  Yes  No
- 5. Does your child have other allergies?.....  Yes  No
- 6. Has your child had any serious illness?.....  Yes  No
- 7. Has your child ever had surgery or been hospitalized?.....  Yes  No
- 8. Has your child had a history of any of the following? **Please check a response for each question:**  
**Circle all that apply if multiple choice.**  
Heart trouble, heart murmur, or heart surgery.....  Yes  No  
Rheumatic fever or scarlet fever.....  Yes  No  
Asthma, TB, or lung problems.....  Yes  No  
HIV infection or AIDS.....  Yes  No  
Hemophilia or bleeding problems.....  Yes  No  
Sickle cell anemia/blood disorder.....  Yes  No  
Hepatitis or liver problems.....  Yes  No  
Kidney infection.....  Yes  No  
Diabetes.....  Yes  No  
Cancer, tumor, leukemia.....  Yes  No  
Thyroid or other glandular problems.....  Yes  No  
Latex or rubber allergy.....  Yes  No  
Epilepsy, seizures, fainting.....  Yes  No  
Cerebral palsy or developmental delay.....  Yes  No  
Vision problems.....  Yes  No  
Speech or hearing problems.....  Yes  No  
Emotional or psychological problems.....  Yes  No  
Congenital birth defects.....  Yes  No  
Cleft lip or palate.....  Yes  No  
Malignant hyperthermia.....  Yes  No  
Other medical condition.....  Yes  No  
Is parent or patient pregnant?.....  Yes  No  
Other.....  Yes  No

**PURPOSE OF TODAY'S VISIT:** \_\_\_\_\_

**DENTAL HISTORY**

- 1. When and where was your child's last dental visit? \_\_\_\_\_
- 2. What was the purpose of that visit? \_\_\_\_\_
- 3. Were any x-rays taken at your child's last dental visit?.....  Yes  No
- 4. Did your child have difficulty cooperating?.....  Yes  No
- 5. Was/is your child bottle fed?.....  Yes  No
- 6. Was/is your child breast fed?.....  Yes  No
- 7. If your child has been weaned, please indicate at what age: \_\_\_\_\_
- 8. When does your child brush his/her teeth?  
 Upon arising  After eating any food  
 Right after meals  Before going to bed
- 9. Do you assist/supervise your child's brushing?....  Yes  No
- 10. Does your child take fluoride supplements? .....  Yes  No
- 11. Have any cavities been noted in the past?.....  Yes  No
- 12. Were any teeth (baby or permanent) removed by extraction?.....  Yes  No
- 13. Have there been any injuries to teeth, such as falls, blows, chips, etc.?.....  Yes  No
- 14. Has anyone in the family, including parents, had orthodontics?.....  Yes  No
- 15. Has your child had a toothache recently?.....  Yes  No  
If yes, explain: \_\_\_\_\_
- 16. Do you expect your child to be cooperative?....  Yes  No
- 17. Does your child have other siblings seen by us?  Yes  No

**CONSENT**

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. Beth E. Kailes and her staff to perform such treatment, services, medication, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date



**OFFICE FINANCIAL POLICY**

**We are pleased you have chosen our office for you child’s dental care. We are dedicated to providing the best treatment for our patients and fees are based on the most appropriate treatment for your child. We need your understanding and cooperation in the following guidelines regarding the filing of your insurance claims and payment.**

**\*Our office may be contracted as a preferred provider for your insurance company. If your insurance is through a company with whom we are not contracted, please check your contract carefully to determine if you are required to see a preferred provider for that company. Understand that if you choose to see a non-preferred provider, your insurance may not pay the full amount or pay at all.**

**\*All applicable deductibles, co-payments, and co-insurance amounts are due at the time services are rendered. We accept cash, checks, Master Card, Visa, Discover, American Express and Care Credit. Some dental services may not be covered by your contract. In the event a given procedure is not covered for any reason (i.e. frequencies limitations, benefit maximum reached) payment for these services is your responsibility. You are responsible for payment regardless of any insurance company’s arbitrary determination of fees.**

**\*A charge of \$25.00 will be assessed on any returned checks. A service fee will be added to accounts turned over to our collection agency and you will be responsible for any additional collection fees.**

**\*A 24 hour notice is required for cancellation of an appointment. There is a \$35 fee for missed or cancelled appointments without 24 hour notice.**

**\*While the filing of insurance claims is a courtesy we gladly extend to you, ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**

***Dr. Kailes recommends doing fluoride treatments on children every six months. The frequency of x-rays depends on your child's risk for decay and individual needs. Please be aware that your insurance may or may not cover the fluoride or x-rays recommended.***

***I authorize the recommended fluoride treatment for my child/children even though my insurance may not cover it. I understand that I am responsible for all charges if my insurance does not cover the procedure. Yes \_\_\_\_\_ No \_\_\_\_\_***

***I authorize the recommended x-rays for my child/children even though my insurance may not cover them. I understand that I am responsible for all charges if my insurance does not cover the procedure. Yes \_\_\_\_\_ No \_\_\_\_\_***

**HIPPA AUTHORIZATION**

**I acknowledge that I have read and comply with the Notice of Privacy Practices of Dr. Beth E. Kailes, DMD, P.A.**

**By my signature, I acknowledge the above office financial policy & Hippa authorization and agree to comply with said policy.**

**Signature of Responsible Party \_\_\_\_\_**

**Date \_\_\_\_\_**

**Responsible Party Name \_\_\_\_\_**

**Patient name/s: \_\_\_\_\_**