PATIENT REGISTRATION

First Name:_____ Last Name: _____MI____

Responsible Party: (if someone other than the patient)

First Name:_____Last Name: _____Middle Initial:____

Address: _____Address 2:_____

City_____ State_____ Zip: _____

Home Phone:_____Work Phone: _____Cell Phone:_____

Birth date: _____Social Security #:_____Drivers Lic#:_____

○ Responsible Party is Policy Holder for Patient ○ Primary Policy Holder ○ Secondary Policy Holder

Patient Information:

First Name:_____ Last Name: _____MI____

Address: _____

City_____ State_____ Zip:_____

Sex: ○ Female ○ Male Birth date:_____

Primary Insurance Information:

Name of Insured:_____ Primary ID#: _____

Insured Social Security #: _____Insured Birth date: _____

Employer:_____ Insurance Company:_____

Secondary Insurance Information:

Name of Insured:_____ Secondary ID#: _____

Insured Social Security #: _____Insured Birth date: _____

Employer:_____ Insurance Company:_____

The Loose Tooth

The Loose Tooth Pediatric Dentistry Medical History

Patient Name: Birth Date: Date Created:

Pediatrican's Name, Phone Number, and Address:

Dental History:

Has your child ever had problems receiving dental	Yes No	If yes
Is this your child's first dental visit?	Yes No	If yes
Is there a particular problem with your child's teeth that prompted you to bring him/her to our office?	Yes No	If yes
Does your child have habits (Thumb, Pacifier)	Yes No	If yes
Does your child need antibiotic treatment prior to their dental appointment?	Yes No	

Allergies:

Is your child allergic to any of the following?

Latex	Yes No
Amoxicillin/Penicillin	Yes No
Anesthetic	Yes No
Nickel	Yes No
Other	Yes No

Medical Background:

Has your child ever had any of the following?

Congenital Heart Defect	Yes No
Heart Murmer	Yes No
Rheumatic Fever	Yes No
Cancer	Yes No
Diabetes	Yes No
Liver Problems	Yes No
Hepatitis	Yes No
Autism	Yes No
Kidney Problems	Yes No
Joint Replacement	Yes No
Excessive Bleeding (Hemophilia)	Yes No
Epilepsy/Seizures	Yes No
Psychological Disorders	Yes No
Nevous System Disorders	Yes No
Cerebral Palsy	Yes No
HIV/AIDS	Yes No
Turberculosis	Yes No
Lung Problems	Yes No
Asthma	Yes No
Sinus Problems	Yes No
ADHD	Yes No
Spina Bifida	Yes No
Development/Intellectual Disabilit	Yes No
Anemia	Yes No
Behavioral Issues	Yes No
Cleft Lip/Palate	Yes No
Sickle Cell Anemia	Yes No
Speech Delay	Yes No
Down Syndrome	Yes No
Other?	Yes No

Medications:

Is your child taking any medications?	Yes No	If yes

I have read and understand the above questions, and this office's privacy policies. I will not hold The Loose Tooth Pediatric Dentistry responsible for any errors or omissions. I also understand that this information will be held in the strictest confidence and that it is my responsibility to inform this office
of any later changes. I understand, where appropriate, credit bureau reports may be obtained.

Signature of Patient, Parent or Guardian:

The Loose Tooth
Pediatric Dentistry

Pediatric Dentistry Informed Consent for Patient Management Techniques

Please read carefully and feel free to ask questions. We will be happy to explain it further. It is our intent that our dental. care delivery be the best available. We are highly experienced in helping children overcome anxiety and we ask that you allow your child to accompany us through the dental experience. Dental anxiety is not uncommon in children so please try to not be concerned if your child exhibits some negative behavior: this is normal and will soon lessen with time. Studies and experience have shown that most children react more positively when permitted to experience the dental visit in an environment designed for children.

Every effort will be made to obtain your child's cooperation through warmth, charm, humor, and understanding. When these fail, there are several behavior management techniques our office uses to minimize disruptive behavior. The techniques used are recommended by the American Academy of Pediatric Dentistry and are described below.

- **Tell-Show-Do:** The dentist or assistant first explains to the child what is to be done, then demonstrates on a model or on the child's finger. Finally, the procedure is completed on the patient's tooth. Praise is used to reinforce cooperative behavior.
- **Positive Reinforcement:** This technique rewards the child who displays any desirable behavior. The rewards include compliments, praise, or a prize.
- **Voice Control:** The attention of a disruptive child is gained by changing the tone, increasing, or decreasing the volume of the practitioner's voice.
- **Mouth Props:** A rubber device is gently placed in the child's mouth to prevent either intentional or unintentional closure on the dentist's fingers or drill.
- **Touch and Go by Dentist/Assistant:** Our assistants ask the child to hold their hand to prevent from grabbing a moving drill or a sharp object. They are not able to grab the practitioner's hand while delicate work is being performed. This is for the safety of the child and to facilitate treatment.

The following will be used after obtaining consent from the parent/guardian

- **Laughing gas:** Nitrous oxide (Laughing gas) is administered to calm and sooth the patient prior to a dental procedure. Nitrous oxide is a very safe medication that on a rare occasion may cause nausea. We ask that your child not eat four hours prior to the nitrous oxide procedure.
- **Protective Immobilization:** This is an immobilizing device (papoose) to limit the patient's disruptive movements and to prevent injury. It is used **only** as a last resort when treatment **cannot** be accomplished in any other way.

The above listed pediatric dentistry behavior management techniques have been explained to me. I understand their use, and the risks /benefits/alternatives available. I have had all my questions answered and I realize I can always seek further information or revoke permission for any of these techniques.

Parent/Guardian signature_____ Date:_____

Childs Name:_____ Date of Birth:_____

The Loose Tooth
Pediatric Dentistry

Financial Responsibility

INSURANCE

Our office is committed to helping our patients maximize their benefits. Your estimated patient portion, deductibles, co-pay amounts, and non-covered services must be paid at the time of service. As a service to our patients we will bill insurance companies for services and allow them 30 days to render payment in full. After 30 days you are responsible for the entire balance and it will be due in full. Insurance policies vary greatly therefore we can estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts. Any questions regarding your benefits should be directed to your insurance carrier directly.

MISSED APPOINTMENTS

Once an appointment has been made, please remember that this time has been reserved specifically for you. If you are unable to make it to your childs appointment we ask that you give our office 24 business hours before rescheduling the appointment. A standard fee of $40.00 dollars will be charged to your account for any dental appointments cancelled or failed within 24 business hours of the scheduled appointment time, $60 dollars for the second time, $80 dollars for the third time and possible dismissal from our office the fourth time. Note: All cancellation fees must be paid prior to scheduling future appointments with our office. When we reserve time for you we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive 15 or more minutes late the appointment is considered as missed and the missed appointment fee will apply, we will then reserve the right to reschedule your appointment.

PAYMENT TYPES

We accept VISA, MC, AMEX,A DISCOVER. We also offer care credit and spring stone as a third party payment plan in our office.

FINANCIAL CHARGES AND COLLECTION FEES

Finance charges will be applied to all balances not paid within 30 days of the monthly billing date. In the event that this account goes unpaid and we are forced to use an outside collection agency and / or an attorney, it is understood and agreed to that up to 30% of the principal amount due will be added as collection fees. If we are forced to file a lawsuit, it is understood and agreed to that you will be liable for all court costs whether judgment has been entered or not.

FINANCIAL CONSENT

The Responsible party agrees to be fully responsible for total payment of treatment performed in this office.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

The Loose Tooth Pediatric Dentistry

15041 S. Van Dyke Rd, #105

Plainfield, IL 60544

815.267.7299

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy of The Loose Tooth's *HIPAA Notice of Privacy Practices*.

I understand that The Loose Tooth's *HIPAA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of The Loose Tooth's revised *HIPAA Notice of Privacy Practices* upon request.

I understand that, if I have questions about The Loose Tooth's *HIPAA Notice of Privacy Practices*, I may contact Rhiannon Holcombe, DDS.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that The Loose Tooth will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding The Loose Tooth's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please ask Rhiannon Holcombe, DDS, noted above, for assistance.

_____ Patient Signature

_____ Date

_____ Signature of Personal Representative

_____ Print Name of Personal Representative

_____ Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

The Loose Tooth made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its *HIPAA Notice of Privacy Practices*. In spite of these efforts, Th Loose Tooth was unable to obtain a signed Acknowledgement for the following reason(s):

- ☐ Refusal to sign Acknowledgement on _____, 20_____.
- ☐ Communications barriers prohibited us from obtaining a signed Acknowledgement.
- ☐ An emergency situation prohibited us from obtaining a signed Acknowledgement.
- ☐ Other (Describe):_____

Date Received	By	Patient ID

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

The Loose Tooth Pediatric Dentistry

15041 S. Van Dyke Rd, #105

Plainfield, IL 60544

Know Your Rights

Your decision to sign this Authorization is voluntary. The Loose Tooth will not refuse treatment to you if you refuse to sign this Authorization. This authorization gives The Loose Tooth permission to speak about your child's case.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

Patient/Parent Signature

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting The Loose Tooth to release, use or disclose my protected health information.

Signature _____ Date _____

Print Name _____ Witness (Optional) _____

Representative Signature

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use or disclosure the patient's protected health information.

Signature _____ Date _____

Print Name _____ Relationship to Patient _____

☐ Parent ☐ Guardian ☐ Power of Attorney

FOR OFFICE USE ONLY

Date Received	By	Patient ID