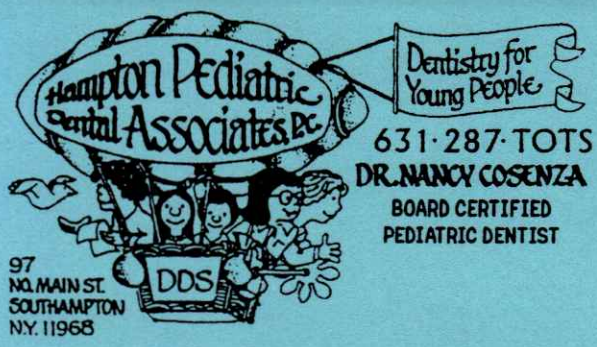


Southampton, NY 11968
(631) 287-TOTS

CHILD'S REGISTRATION AND HISTORY

Date_____

Child's Name_____ Nickname_____

First Middle Last

Male ____ Female _____ Birthdate_____ Age_____ School_____ Grade_____

Mailing Address _____

Residence _____

Town _____ Zip _____ Home Phone _____

Parents are: Married _____ Separated _____ Divorced _____ Single _____

Father's / Guardian's name _____ Employed by _____

Father's Employer's Address_____

Father's home phone _____ Work phone _____ Cell _____

Father's address _____ Father's Social Security #_____

Father's date of birth _____

Mother's / Guardian's name _____ Employed by _____

Mother's Employer's Address_____

Mother's home phone _____ Work phone _____ Cell _____

Mother's address _____ Mother's Social Security #_____

Mother's date of birth _____

Is this an emergency visit? Y N If no, reason for visit _____

Is this your child's first dental visit? Y N

If no, name of former dentist _____ Date of last visit _____ Purpose _____

Have any other children in your family been a patient in this office before? Y N

Name of family dentist? _____

Whom may we thank for referring you to our office? _____

DENTAL INFORMATION

	Yes	No	
Was your child bottle fed? _____ Was your child breast fed? _____	❑	❑	If yes, until what age
Has your child had any injuries to his teeth, mouth, head or jaws?	❑	❑	If yes, describe

Does/did your child have any of the following habits? ❑ Use of nursing bottle ❑ nail biting

❑ finger sucking ❑ thumb sucking ❑ pacifier ❑ tongue thrusting ❑ mouth breathing ❑ teeth grinding

Does your child receive fluoride in any of the following forms:

❑ In vitamins tablets/drops Vitamin name:_____ Dosage:_____ mg/day ❑ In water supply ❑ In toothpaste ❑ in rinse/g

How has your child reacted for previous dental visits? ❑ Positive ❑ Negative If negative, explain_____

How do you expect your child to react to this visit today?_____

_____

Date of last physical and reason _____

	Yes	No
Is your child in good health?	❑	❑
Are your child's immunizations up to date?	❑	❑
Is your child being treated for any conditions presently?	❑	❑
If so, explain _____		
Is your child taking any medications or drugs? (Including vitamins)	❑	❑
If so, explain _____		
Has your child ever been hospitalized/had surgery or received general anesthesia or sedation?	❑	❑
If so, explain _____		
Does your child have any allergies or reactions to any medications? Environment? Food or food dyes?	❑	❑
If so, explain _____		

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Yes	No		Yes	No		Yes	No	
❑	❑	AIDS	❑	❑	Chronic Ear Infections	❑	❑	Heart Murmur/Heart Defect
❑	❑	Allergies to Medicine	❑	❑	Bleeding Disorders	❑	❑	Hyperactivity
❑	❑	Asthma	❑	❑	Convulsions/Seizures	❑	❑	Mental Retardation
❑	❑	Cancer or Malignancies	❑	❑	Developmental Delay	❑	❑	Premature Birth
❑	❑	Cerebral Palsy	❑	❑	Excessive Gagging	❑	❑	Tuberculosis
❑	❑	Chronic Adenoid/Tonsil Infection	❑	❑	Hearing/Speech Problems			

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that has not been covered._____

_____

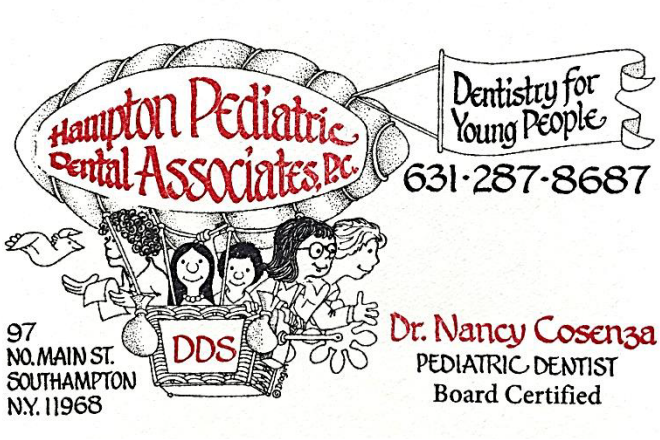
THIS IS A PRIVATE PRACTICE: In order to keep our cost down while providing excellent dental care, we do not accept insurance. Payment is required at the time services are performed. If you have dental insurance and would like us to file your claim please fill out the information below and your insurance company will reimburse you according to your plan.

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

Because your child is a minor, it becomes necessary that signed permission be obtained from a parent or guardian before any/all necessary services can be performed. I acknowledge that the above information is correct. I authorize the doctor to take x-rays, photographs or other diagnostic aids deemed appropriate to make a thorough diagnosis and grant this office permission to provide my child's dental treatment. This consent is also valid for emergency treatment, if necessary, even in my absence. Furthermore, I understand that I am responsible for the cost of this dental care.

X _____ _____

(Signature of parent or guardian) (Date)



PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

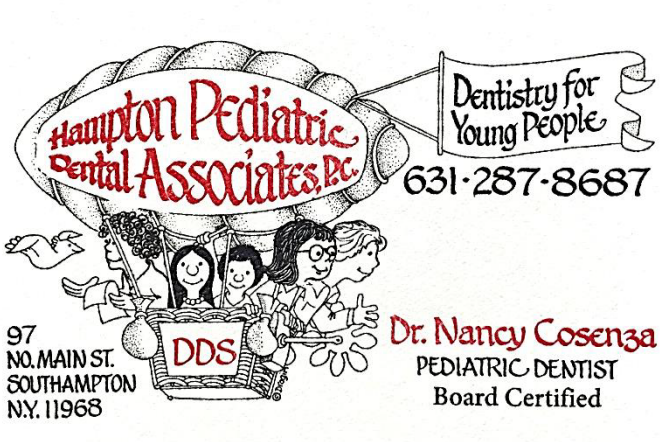
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient Name:_____

Relationship to Patient:_____

Signature: _____



PAYMENT AGREEMENT

By signing this form I understand that Hampton Pediatric Dental Associates will bill my child's insurance first for my child's treatment today. If for any reason the insurance company does not pay any or part of the bill I will be responsible for payment.

Date: _____

Print Patient Name:_____

Relationship to Patient:_____

Signature: _____