ARQUITT
Pediatric Dentistry
Growing healthy smiles

Patient Registration

Please Print

Today's Date: ______________________________

Referred By: ______________________________

PATIENT INFORMATION

Last Name: ____________________ First Name: ____________________ MI ________

Date of Birth: ______________________________ Male: ❑ Female: ❑

SIBLINGS:

Last Name: ____________________ First Name: ____________________ MI ________

Date of Birth: ______________________________ Male: ❑ Female: ❑

Last Name: ____________________ First Name: ____________________ MI ________

Date of Birth: ______________________________ Male: ❑ Female: ❑

RESPONSIBLE PARTY

Last Name: ____________________ First Name: ____________________ MI ________

Occupation: ______________________________

Address City: : ______________________________ State: ________ Zip : ____________

Phone: (________) ____________-____________ Work Cell : (________) ____________-____________

SS#: ____________________ Date of Birth: ____________________ Male: ❑ Female: ❑

Relationship to patient: ____________________ Email address: ____________________

INSURANCE

Policyholder______________________________

Patient relationship to policyholder______________________________

Insured SS #: ____________________ Insured Date of Birth: ____________________

Employer: ____________________ Occupation: ____________________

If unable to provide insurance card, please fill out the following.

Insurance Company: ______________________________ Group #: ____________________

Phone: (______) __________-____________ Emergency Contact Phone: (______) __________-____________

NOTICE OF PRIVACY PRACTICES

This facility has posted a copy of the Privacy Practice in the lobby. If you would like a copy, one will be provided at your request.

I have reviewed a copy of the Privacy Practices of this office.

Relationship to Patient: ______________________________

Signature of Responsible Party: ______________________________ Date: ____________

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Medical History

NAME OF CHILD ______________________ Date of Birth ______________

Name of Child's Physician ______________________ Office Phone ______________

Date / reason for last visit ______________________

Are vaccinations current: ☐ yes ☐ no

Allergies / Adverse drug reactions ______________________

____

____

Does your child have an allergy to Latex? ______________________ ☐ yes ☐ no

Current medications ______________________

Previous medications ______________________

Is your child in good health? .... ☐ yes ☐ no

Any difficulties with pregnancy or birth? .... ☐ yes ☐ no

Does your child have any special needs? .... ☐ yes ☐ no

If yes, explain ______________________

Has your child ever been hospitalized / had an emergency room visit? .... ☐ yes ☐ no

If yes, explain ______________________

Has your child ever had general anesthesia or sedation? .... ☐ yes ☐ no

If yes, explain ______________________

Has your child ever had problems with or been treated by a doctor for:

Heart / heart murmur	☐ yes ☐ no	Eyes	☐ yes ☐ no
Artificial valve / joint	☐ yes ☐ no	Speech / hearing	☐ yes ☐ no
Rheumatic fever	☐ yes ☐ no	Tonsils / adenoids	☐ yes ☐ no
Birth defects	☐ yes ☐ no	Liver / GI	☐ yes ☐ no
Seizures / Epilepsy	☐ yes ☐ no	Diabetes/Endocrine	☐ yes ☐ no
Cancer/tumors	☐ yes ☐ no	Hepatitis	☐ yes ☐ no
Headaches	☐ yes ☐ no	AIDS or HIV+	☐ yes ☐ no
Arthritis	☐ yes ☐ no	TB /lung disease	☐ yes ☐ no
Learning problems	☐ yes ☐ no	Bleeding/Hemophilia	☐ yes ☐ no
Behavioral problems	☐ yes ☐ no	Blood transfusion	☐ yes ☐ no
Mental disorders	☐ yes ☐ no	Anemia	☐ yes ☐ no
Autism	☐ yes ☐ no	Asthma	☐ yes ☐ no
Down Syndrome	☐ yes ☐ no	Skin	☐ yes ☐ no
Mentally Challenged	☐ yes ☐ no	Cleft lip/ palate	☐ yes ☐ no
Hives or Rashes	☐ yes ☐ no	Arthritis	☐ yes ☐ no
Genetic abnormality	☐ yes ☐ no	Pregnancy	☐ yes ☐ no
Drug /alcohol addiction	☐ yes ☐ no	Use tobacco products	☐ yes ☐ no

Other: ______________________

If female, age of first menstrual period ______________________

Do you consider your child to be: ☐ advanced ☐ progressing normal ☐ slow learner

Is there any other information about your child we should know?

____

Relationship to Patient: ______________________

Signature of Responsible Party: ______________________ Date: ______________

Dental History

NAME OF CHILD ______________________________

What is your major dental concern about your child? ______________________________

Name of previous Dentist ______________________________

Date of last dental x-rays ______________________________

Reason for leaving former dentist ______________________________

Has your child experienced an unusual reaction to dental medications or anesthetic? ______________________________

____

Has your child had any prolonged bleeding or complications after dental treatments? ______________________________

____

Does your child complain of any of the following? (Please check)

- ☐ Toothache
- ☐ Dental abscess
- ☐ Sensitivity
- ☐ Gum bleeding
- ☐ TMJ pain or popping
- ☐ Mouth ulcers
- ☐ Cavities
- ☐ Facial swelling

Please check all forms of fluoride your child has exposure to:

☐ toothpaste ☐ rinses ☐ supplements ☐ other ______________________________

Is there fluoride in your drinking water? ☐ yes ☐ no ☐ unknown

What beverages does your child drink? ______________________________

How many times a day is your child's teeth brushed? __________ who brushes? ______________________________

Has your child had an injury to the teeth, jaws, or face? ______________________________

____

Are you unhappy with the appearance of your child's teeth? ______________________________

____

Was your child ☐ bottle or ☐ breast fed? At what age was this stopped? ______________________________

Does your child suck their fingers, thumb, or a pacifier? ______________________________

Has your child inherited any family dental characteristics? Please explain: ______________________________

____

Do you think your child will cooperate for dental treatment? ______________________________

Has your child ever had ☐ nitrous oxide ☐ sedation ☐ general anesthesia *please explain:* ______________________________

____

Are you aware some children may cry, yell, or move around during dental treatment? ______________________________

If so do you have any concerns or questions about this? ______________________________

____

Please make note of any other dental concerns or complaints: ______________________________

____

Signature of Responsible Party: ______________________________ Date: ______________________________

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Consent for Treatment • Financial Agreement
Photo Consent • Assignment of Benefits Authorization

As responsible party for (patient name) ____, I hereby give consent for the following Dental Treatments and evaluations to be performed by the Dental Professionals of Arquitt Pediatric Dentistry LLC.

- Cleaning including Fluoride treatment
- X- Rays for diagnosis and evaluation
- Fillings
- Extractions
- Caps or Crowns
- Nitrous Oxide (used to keep the patient comfortable)
- Space maintainers
- Nerve treatments" pulpotomy"

All treatment plans and financial responsibilities will be discussed with the Responsible Party prior to beginning treatment. Parents are welcome and encouraged to share in the initial visit by joining the child for their cleaning and exam. Children are encouraged to come back for their restorative procedures on their own to facilitate the doctor patient relationship.

Cancellations or missed appointments: We understand that circumstances change and unexpected family commitments can alter every day plans. Please let us know as soon as possible so that we may offer your appointment time to another family that maybe waiting to be seen. If an appointment is missed, and we do not hear from the responsible party, the child's appointment will be logged as a "failed appointment". Two Failed appointments will be forgiven but three will result in being dismissed from the practice. Arquitt Pediatric Dentistry, LLC reserves the right to charge a $50 fee for missed appointments.

- I understand that I am personally responsible for any and all charges incurred by the patient from services rendered by Arquitt Pediatric Dentistry LLC
- Unless other arrangements are made in advance with the financial department of Office Manager, the total charges are due and payable at the time of services.
- I understand that it is the Policy of Arquitt Pediatric Dentistry LLC to file my dental claims and have the insurance payer to mail reimbursement directly to the address provided.

I understand that my insurance company does not guarantee benefits over the phone. The portion of coverage by my insurance is an ESTIMATE. I understand that an insurance policy is as contract between me and an insurance carrier and that I am personally responsible for charges rendered by Arquitt Pediatric Dentistry LLC regardless of claim status. I acknowledge that payment is due at the time of treatment and I except fun financial responsibility for all charges not covered by insurances. If the account is referred to a collection agency I am responsible for the balance in addition to any collection agency fees and or attorney fees that are incurred.

I hereby agree to all terms set forth herein and authorize treatment, and release of any medical information necessary to process my insurance claims.

Signature of Responsible Party: ____________________________________ Date: _____________________

Address of Responsible Party: ____

City: ______________________________________ State: _______ Zip: _____________

PHOTO CONSENT: As a pediatric specialty office, Arquitt Pediatric Dentistry, LLC frequently offers continuing education for parents, children and physicians that may have questions about oral healthcare. We would like permission to take photos of your child's teeth. The photo would not include a name.

I hereby give consent for Arquitt Pediatric Dentistry, LLC to take photos of my child's teeth for training and education purposes only. I understand that this will not be used for advertising and will not be used for any other purpose other than education.

Signature of Responsible Party: ____________________________________ Date: _____________________