HENDRICKS PEDIATRIC DENTISTRY 1411 S. GREEN STREET, #200 BROWNSBURG, IN 46112
Ph: (317) 852-8113 Fax: (317) 852-8115

# PATIENT REGISTRATION

**Patient Name**_______________________________________________ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)

Nickname/Preferred to be called_____________________________ Social Security #_____-_____-______

**Sex**: M / F **Ethnicity**: White / Black / Hispanic / Other: ______________________________

Any Dental Concerns or any additional information we should be aware of?____________________________

______________________________________________________________________________

______________________________________________________________________________

**Address** _____________________________________ City ______________________ Zip _____________

Preferred Phone # (_____)_______________________ Email: _____________________________________

Patients live with (circle one) (both parents), (grandparents), (single parent) (Other) ______________________

*****The person who brings the child is the responsible party for consent of treatment and payments.***

**Previous Dentist**

Has patient been to a dentist in the past? YES NO (if NO, skip dentist information)

Dentist Name ______________________________________________ Phone (____)_______________

Address ___________________________________________________________________________

Were any X-rays taken? YES NO Date of last cleaning/Fluoride Treatment____/____/_______

**Guardian Information**

Name _____________________________________
(First) (Middle Int.) (Last)

Relationship to patient _________________________

Soc.Sec. # __________________________________

Birth date __________/___________/ ____________

Address ____________________________________
(If different from above) (Street)

____________________________________________
(City) (State) (Zip code)

Phone: (Home) (___) _________________________

(Work) (___) _________________________

(Cell) (___) _________________________

Employer: __________________________________

Employer Address: ___________________________

**Additional Guardian Information**

Name _____________________________________
(First) (Middle Int.) (Last)

Relationship to patient: ________________________

Soc. Sec. # __________________________________

Birth date __________/___________/ ____________

Address ____________________________________
(If different from above) (Street)

____________________________________________
(City) (State) (Zip code)

Phone: (Home) (___) _________________________

(Work) (___)__________________________

(Cell) (___)__________________________

Employer: __________________________________

Employer Address: ___________________________

**Emergency Contact:** Name:___________________________________ Phone: (___)____________________

**Dental Insurance:** **YES** **NO** **MEDICAID:** Certificate #______________________

**PRIMARY**

Subscriber name: ____________________________ Subscriber D.O.B. ______/_______/______________

Subscriber Soc. Sec. #__________________________ Subscriber ID# ____________________________

Group Name: _______________________________ Group #: _________________________________

Insurance Company Name: ____________________ Insurance Company Phone # ___________________

Insurance Company Address: __________________________________________________________

**SECONDARY**

Subscriber name: ____________________________ Subscriber D.O.B. ______/_______/______________

Subscriber Soc. Sec. #__________________________ Subscriber ID# ____________________________

Group Name:_________________________________ Group #: _________________________________

Insurance Company Name: ____________________ Insurance Company Phone # ___________________

Insurance Company Address: __________________________________________________________

**Whom can we thank for referring you to our practice?** _________________________________

## **Additional Patients** ______________________________________________

**Patient Name**_______________________________________ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called______________________ Social Security #_____-_____-______
**Sex**: M / F **Ethnicity**: White / Black / Hispanic / Other: ______________________
Any Dental Concerns or any additional information we should be aware of?____________________
______________________________________________________________________

**Patient Name**_______________________________________ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called______________________ Social Security #_____-_____-______
**Sex**: M / F **Ethnicity**: White / Black / Hispanic / Other: ______________________
Any Dental Concerns or any additional information we should be aware of?____________________
______________________________________________________________________

**Patient Name**_______________________________________ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called______________________ Social Security #_____-_____-______
**Sex**: M / F **Ethnicity**: White / Black / Hispanic / Other: ______________________
Any Dental Concerns or any additional information we should be aware of?____________________
______________________________________________________________________

**Patient Name**_______________________________________ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called______________________ Social Security #_____-_____-______
**Sex**: M / F **Ethnicity**: White / Black / Hispanic / Other: ______________________
Any Dental Concerns or any additional information we should be aware of?____________________
______________________________________________________________________

**Patient Name**_______________________________________ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called______________________ Social Security #_____-_____-______
**Sex**: M / F **Ethnicity**: White / Black / Hispanic / Other: ______________________
Any Dental Concerns or any additional information we should be aware of?____________________
______________________________________________________________________

**Patient Name**_______________________________________ Birth date_____/_____/______
(First) (Middle) (Last) (Month/Day/Year)
Nickname/Preferred to be called______________________ Social Security #_____-_____-______
**Sex**: M / F **Ethnicity**: White / Black / Hispanic / Other: ______________________
Any Dental Concerns or any additional information we should be aware of?____________________
______________________________________________________________________

Additional Notes: ______________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

# MEDICAL-DENTAL HISTORY

**Today's Date: ________________________**

Child's Name______________________________________ Sex____ Birth Date___________ Place of Birth ________________
Last, first, nickname

Date of last medical examination______________ Child's Physician/pediatrician_____________________ Telephone ___________

Physician's address ___________________________________________________________________________________

## ***PLEASE EXPLAIN ANY "YES" ANSWERS IN THE MARGINS***

### MEDICAL HISTORY

**GROWTH AND DEVELOPMENT:**

| | | |
|---|---|---|
| Any learning, behavioral, excessive nervousness, or communication problems? (If yes, indicate below) | No ( ) | Yes ( ) |
| **Diagnosis** (circle): ADD/ADHD Autism Spectrum Bipolar Dev. Delay OCD ODD PTSD Speech Delay Other: ________________________________ | | |
| Has child had psychological counseling or is counseling being considered for the near future? | No ( ) | Yes ( ) |
| Were there any complications during pregnancy or was child premature at birth? | No ( ) | Yes ( ) |
| Any problems with physical growth? | No ( ) | Yes ( ) |

**CENTRAL NERVOUS SYSTEM:**

| | | |
|---|---|---|
| Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness? | No ( ) | Yes ( ) |
| Any history of injury to the head | No ( ) | Yes ( ) |
| Any sensory disorders (seeing, hearing)? | No ( ) | Yes ( ) |

**CARDIOVASCULAR SYSTEM:**

| | | |
|---|---|---|
| Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever? | No ( ) | Yes ( ) |
| Has any heart surgery been done or recommended? | No ( ) | Yes ( ) |
| Any history of chest pains or high blood pressure ? | No ( ) | Yes ( ) |

**HEMATOPOIETIC AND LYMPHATIC SYSTEMS:**

| | | |
|---|---|---|
| Has your child ever had a blood transfusion or blood product transfusion? | No ( ) | Yes ( ) |
| Any history of anemia or sickle cell disease? | No ( ) | Yes ( ) |
| Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts? | No ( ) | Yes ( ) |
| Is your child more susceptible to infections than other children? | No ( ) | Yes ( ) |
| Is there any history of tender or swollen lymph nodes or glands? | No ( ) | Yes ( ) |

**RESPIRATORY SYSTEM:**

| | | |
|---|---|---|
| Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty breathing? | No ( ) | Yes ( ) |

**GASTROINTESTINAL SYSTEM:**

| | | |
|---|---|---|
| Any history of stomach, intestinal or liver problems | No ( ) | Yes ( ) |
| Any history of hepatitis or jaundice? | No ( ) | Yes ( ) |
| Any history of eating disorders, such as anorexia nervosa or bulimia? | No ( ) | Yes ( ) |
| Any history of unintentional weight loss? | No ( ) | Yes ( ) |

**GENITOURINARY SYSTEM:**

| | | |
|---|---|---|
| Any history of urinary tract infections, bladder or kidney problems? | No ( ) | Yes ( ) |
| Is the patient pregnant or possibly pregnant? | No ( ) | Yes ( ) |

**ENDOCRINE SYSTEM:**

| | | |
|---|---|---|
| Any history of diabetes? | No ( ) | Yes ( ) |
| Any history of thyroid disorders or other glandular disorders? | No ( ) | Yes ( ) |

**SKIN:**

| | | |
|---|---|---|
| Any history of skin problems? (circle): Eczema Other:__________________________________________ | No ( ) | Yes ( ) |
| Any history of cold sores (herpes) or canker sores (aphthae)? | No ( ) | Yes ( ) |

**EXTREMITIES:**

| | | |
|---|---|---|
| Any limitations of use of arms or legs? | No ( ) | Yes ( ) |
| Any arthritis, joint bleeding, joint replacements, or other joint problems? | No ( ) | Yes ( ) |
| Any problems with muscle weakness or muscular dystrophy? | No ( ) | Yes ( ) |

**ALLERGIES:**

| | | |
|---|---|---|
| Is your child allergic to any medications? | No ( ) | Yes ( ) |
| If Yes, List: __________________________________________________________________________ | | |
| Any hay fever, hives, or skin rashes caused by allergies? | No ( ) | Yes ( ) |
| Any other allergies? | No ( ) | Yes ( ) |
| If Yes, List: __________________________________________________________________________ | | |

**MEDICATIONS OR TREATMENTS:**

| | | |
|---|---|---|
| Is your child currently taking any medication (prescription or non-prescription)? | No ( ) | Yes ( ) |

| If yes, Medication (s) | Diagnosis | Dosage | Times Per Day |
|---|---|---|---|
| ______________________ | ______________________ | ______________ | __________ |
| ______________________ | ______________________ | ______________ | __________ |
| ______________________ | ______________________ | ______________ | __________ |

| | | |
|---|---|---|
| Has your child ever received therapy (x-ray treatments) or is it planned | No ( ) | Yes ( ) |
| Has your child ever received chemotherapy or is it planned | No ( ) | Yes ( ) |

**HOSPITALIZATIONS:** Has your child ever been hospitalized? No ( ) Yes ( )

| | | | |
|---|---|---|---|
| Hospital | ______________________________ | _______________________________ | ___________________________________ |
| Date | ______________________________ | _______________________________ | ___________________________________ |
| Reason | ______________________________ | _______________________________ | ___________________________________ |

**IMMUNIZATIONS:**

Is your child up to date on vaccines and immunizations? No ( ) Yes ( )

**Please check any of the following that your child has now, has recently been exposed to, or has had in the past.**

| | NOW | EXPOSED | PAST |
|---|---|---|---|
| Chicken pox (varicella) | ______________________ | ______________________ | ______________________ |
| Earache (otitis) | ______________________ | ______________________ | ______________________ |
| Eye infection (conjunctivitis) | ______________________ | ______________________ | ______________________ |
| German measles or 3-day measles (rubella) | ______________________ | ______________________ | ______________________ |
| Glandular fever or mono (infectious mono) | ______________________ | ______________________ | ______________________ |
| HIV/AIDS | ______________________ | ______________________ | ______________________ |
| Lead poisoning | ______________________ | ______________________ | ______________________ |
| Measles (rubella) | ______________________ | ______________________ | ______________________ |
| Mumps (parotitis) | ______________________ | ______________________ | ______________________ |
| Scarlet Fever (scarlatina) | ______________________ | ______________________ | ______________________ |
| Sore throat (tonsillitis or pharyngitis) | ______________________ | ______________________ | ______________________ |
| Substance abuse, alcoholism, drug addiction | ______________________ | ______________________ | ______________________ |
| Tuberculosis | ______________________ | ______________________ | ______________________ |
| Upper respiratory infection (URI) or common cold Pharyngitis, rhinitis, sinusitis, or tonsillitis) | ______________________ | ______________________ | ______________________ |
| Venereal disease (genital herpes, gonorrhea, Syphilis, or other) | ______________________ | ______________________ | ______________________ |

## DENTAL DISEASE PREVENTION & ORAL HABITS

How often does your child brush? _____________________times per________________________

Does your child use dental floss? No ( ) Yes ( )

Does someone assist your child with brushing and cleaning teeth? No ( ) Yes ( )

Does someone inspect for thoroughness after the procedure? No ( ) Yes ( )

Does your child use fluoride toothpaste? No ( ) Yes ( )

Drinking water source: City water supply__________ Name of city________________________

Private well or other than city_____________ Has a fluoride analysis been done? __________

Date of analysis________________________ Fluoride content_________________________

Does your child fail to eat a well-balanced diet? No ( ) Yes ( )

If yes, what foods or food groups are not adequate? _______________________________________

Does (or has) your child have (or had) any of these habits beyond one year of age? (If yes, check) No ( ) Yes ( )

Thumb-sucking _____ Finger-sucking _____ Pacifier _____ Lip biting _____

Mouth breathing _____ Nail biting _____ Teeth grinding _____ Other ____________________________________________________

Does (or has) your child have (or had) difficulty opening his or her mouth, or does the child's jaw sometimes lock or stick in a certain position? No ( ) Yes ( )

Does (or has) your child have (or had) popping or clicking noises or pain during chewing or yawning? No ( ) Yes ( )

Does (or has) your child have (or had) frequent headaches or pain in or about the ears, eyes, or cheeks? No ( ) Yes ( )

## DENTAL HISTORY (*New Patients ONLY*)

Has your child ever had a fluoride treatment? No ( ) Yes ( )

Has your child ever taken a fluoride supplement or vitamins with fluoride? No ( ) Yes ( )

Does your child have a toothache or other immediate dental problems? No ( ) Yes ( )

Has your child ever had a toothache? No ( ) Yes ( )

Has your child had any injury to the mouth, teeth, or jaws (fall, blow, etc.)? No ( ) Yes ( )

Is this your child's first dental visit? No ( ) Yes ( )

If no: Date______________________ Dentist________________________

Reason_____________________________________________________

Has your child ever had an unfavorable dental experience? No ( ) Yes ( )

Is (was) your child nourished by nursing beyond age one? No ( ) Yes ( )

If yes, check: Breast________ Nursing Bottle_________ Both________, and to what age? __________

**DATE: ________________ Signature (Parent or guardian) ________________________________________**

# OFFICE PROCEDURES REGARDING PATIENTS WITH TREATMENT AND CONSENT

Our goal in treating your child is to provide the highest quality care utilizing the most up to date techniques and materials in a safe, friendly environment by our experienced, caring, and well-trained staff. It is our goal to prevent decay and have all of our patients “cavity-free” with great oral health.

However, there are times when treatment is needed. The doctor will discuss the recommended treatment with you and give you the written treatment plan to review. The following are our guidelines for treatment, which we will discuss with you. If you have any questions or concerns regarding these guidelines, please feel free to ask any of our staff doctors, or one of our staff members at any time.

## TREATMENT

We will treat your child the same way we would treat one of our own children while providing dental care to them—with tender, loving care, and honest, sincere concern without strong sedative drugs. We will at times use Nitrous Oxide to help your child relax. The doctor or our staff will discuss this with you prior to the use of Nitrous Oxide.

Since many adults have a fear of dentistry, they wait until they have a serious problem to seek treatment. Most of the treatment we perform on children, such as sealants and small fillings, is to prevent these serious problems. Our goal is to teach your child that dentistry is a health care service that can provide a lifetime of healthy teeth and gums and having dental treatment can be a positive experience. Our job is to educate you and your child about dentistry and establish trust and confidence in your child about dental treatment.

We encourage parents to accompany their child during their initial exam and for routine dental cleanings. However, if your child needs treatment we respectfully ask that whoever accompanies the child to their appointment wait in our lobby. At the doctor’s discretion some situations may allow for exceptions. Our staff will discuss this with you prior to any treatment. This allows the doctor to establish a direct and close rapport with your child. When a parent is in the room, your child’s attention is divided and it is difficult to gain his/her confidence. Most children handle the situation better without the parent present. One of our staff members will come to the reception room and accompany your child to the treatment room. They will stay with your child during treatment and accompany your child back to the reception room after treatment is finished. While you may feel it is a comfort for your child to “walk them back to the room”, we have found this to be a greater problem for your child, because you are “leaving” him/her. If your child knows you are “waiting” for him/her “out front” and he/she will join you at the end of treatment, then you have not “left” or “gone away.” We schedule all operative treatments, such as filling and extractions, in the morning. We have learned from past experience that children are more receptive to this type of treatment in the morning.

## CONSENT

Your child is a minor; therefore it is necessary to obtain signed permission from a parent or guardian before any necessary dental service can be provided. **THE PARENT OR GUARDIAN WHO BRINGS THE CHILD FOR DENTAL TREATMENT IS RESPONSIBLE FOR ALL FEES.** We will be glad to give you the proper receipts necessary for you to get reimbursement, if another party is responsible for the child’s health care costs.

**I grant the doctor permission to provide my child’s dental exam and treatment, including x-rays, study models, photographs, and/or any other diagnostic aid deemed necessary to make a thorough diagnosis, and perform any treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I will be responsible for all costs of this dental care. I authorize Hendricks Pediatric Dentistry to send a dental report to my child’s physician, and/or referring dentist. I authorize the release of any medical information necessary to process insurance claims, and I also request payment of benefits to the dentist. However, if I pay in full at time of service, insurance benefits will be paid directly to me. In the event that it would be necessary to involve a third party to collect all or any part of an amount owed to John R. Wells, D.M.D., P.S.C., they are entitled to the cost of collection. I acknowledge that the above policy has been explained to me along with the recommended treatment, and that my questions have been answered to my satisfaction. Also, by signing this document I acknowledge that I have been offered a copy of this office’s Notice of Privacy Practices. (You may refuse to sign this acknowledgement. However we will not be able to file insurance and payment in full will be due at time of service. Please understand that revocation will not affect any action we took prior to this consent, and that we may decline patient treatment if you revoke this consent.)**

## AUTHORIZATION

I have read & accept the above policies. I understand & agree to the terms set forth regarding payment.
I understand that the above policies apply to all individuals under my account.

Patient(s) Name(s):________________________________________ Date________________

Signature of guardian:______________________________ Relationship to patient(s):____________________

Printed Name of Guardian:________________________________________________

# APPOINTMENT AND FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. ***It is our policy to make definite financial arrangements with you before any treatment starts.*** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

- **Please be on time** for your appointment. **If you cannot make your scheduled appointment and do not call in advance to reschedule or cancel your appointment**, your appointment will be considered as a **"Broken Appointment"**. (This time could have been used to treat another child if we knew you were unable to make your appointment). If the appointment was for a **new** patient, we will **not** be able to accept that child as a patient. We reserve the right to charge a fee for any missed appointment and/or dismiss the patient from our practice.
- Always bring the patient's insurance card.
- Please notify us of any changes of address, phone numbers, and insurance coverage as soon as possible.
- Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards. There will be a $30.00 service charge for all returned checks.
- For new patient emergency visits we require payment in full at the time of the appointment.
- **As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and we will file the insurance for you**
- Our office will file your insurance claim a maximum of **two times** per appointment.
- **If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.** We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.
- You must provide the office with a dental insurance card with the proper mailing address of the insurance company, or provide a dental claim form, which is provided by the employer. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.
- If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. However, if your insurance company does not assign benefits to the doctor, your payment in full is expected at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.
- **The office cannot carry balances longer than 90 days**, regardless if the insurance payment is still pending. We reserve the right to charge billing fees and or employ a collection service to collect payment on accounts with balances older than 90 days. If your account is delinquent, we will not be able to reserve appointment times (other than emergencies) until your account is current.
- **The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree or custody arrangement may state. Reimbursement must be made between the divorced parents. We will not intervene.**

## AUTHORIZATION

I have read & accept the above policies. I understand & agree to the terms set forth regarding payment.
I understand that the above policies apply to all individuals under my account.

Patient(s) Name(s):________________________________________ Date________________

Signature of guardian:______________________________ Relationship to patient(s): ____________________

Printed Name of Guardian: ________________________________________________

HENDRICKS PEDIATRIC DENTISTRY
JOHN R. WELLS, D.M.D.
1411 S. GREEN STREET, SUITE #200
BROWNSBURG, IN 46112

# Patient/Guardian Authorization to Disclose Protected Health Information to Others and Consent to Treat

Patient Name: ______________________________ Birthdate ______________________

Patient Name: ______________________________ Birthdate ______________________

Patient Name: ______________________________ Birthdate ______________________

Patient Name: ______________________________ Birthdate ______________________

Patient Name: ______________________________ Birthdate ______________________

Patient Name: ______________________________ Birthdate ______________________

Patient Name: ______________________________ Birthdate ______________________

I give permission for protected health information to be disclosed to the following person(s). They may also consent to treatment for the above named patients. This includes scheduling appointments, bringing them to appointments, signing treatment consents and approving use of Nitrous Oxide (laughing gas).

Name____________________________________ Relationship ____________________

Name____________________________________ Relationship ____________________

Name____________________________________ Relationship ____________________

Name____________________________________ Relationship ____________________

Name____________________________________ Relationship ____________________

Printed name of legal guardian ________________________________________________

I hereby declare that I am the legal guardian of above named patient(s).

Signature of legal guardian__________________________________________________

Relationship ______________________________ Date __________________________

## *Please provide any legal documentation showing assignment of relationship to patient(s).

**Note:** If at any time you want to update this information it is your responsibility to ask for a new form. The most current form will be honored.