HENDRICKS PEDIATRIC DENTISTRY BROWNSBURG, IN 46112
Ph: (317) 852-8113 Fax: (317) 852-8115 E-mail: info@hendrickspd.com

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) _____

APPOINTMENT AND FINANCIAL POLICY

We are pleased to welcome your family to Hendricks Pediatric Dentistry! Our desire is to provide our patients with the highest quality dental care in a trusting, safe, and enjoyable environment. **It is our policy to make definite financial arrangements with you before any treatment is initiated.** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

- Please be on time. **If you cannot make your scheduled appointment or if you are more than 10 minutes late, and do not call in advance to reschedule or cancel your appointment then your appointment will be considered as a "Broken Appointment".** Following a broken appointment, a letter will be mailed informing you of the missed appointment. If two appointments are broken in a calendar year a dismissal letter will be issued. If the appointment scheduled was for a new patient exam, we will not be able to reschedule that child as a patient. Extenuating circumstances will be considered at the discretion of Dr. Dan.
- We reserve the right to charge a fee for any missed appointment and/or dismiss the patient from our practice.
- If a patient is dismissed from our practice, we will provide appropriate accommodations or emergency care for a period of 30 days following the delivery of the dismissal letter.
- 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, check, and credit cards. There will be a $30.00 service charge for all returned checks and a 4% charge for all card payments.
- For new emergency visits we require payment in full at the time of the appointment.
- **For any emergency outside of normal operating hours an after-hours fee will be incurred by the patient.**
- 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 60 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 copayments 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 feels 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** even 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 greater 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 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:_____

OFFICE PROCEDURES REGARDING PATIENT 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. Through our proactive and preventative approach, we work as a team with each patient to achieve great oral health and "cavity free" visits!

Despite our best efforts, there are times when treatment will be needed. Treatment recommendations are based upon clinical and radiographic exams and are supported by the *American Academy of Pediatric Dentistry's Clinical Practice Guidelines and Best Practice Recommendations.* Proposed treatment will be discussed with the parent/guardian and a written treatment plan will be provided to review and consent to the agreed upon procedures.

TREATMENT PROTOCOLS

It is our mission to provide an ethical, comprehensive, and welcoming dental home for our patients. If treatment is required, we strive to provide the best, individualized dental care in a calm and comfortable manner. Each patient who visits our office will receive our upmost attention and will be treated as one of our own children. In addition to addressing dental decay, another essential component of our office is oral health education. We strive to be proactive in our office to inspire exceptional oral health. By emphasizing oral health education and building rapport with our patients we believe we can cultivate a generation of children with healthy smiles and a lifelong trust of the dentist.

To facilitate a calm environment and comfortable treatment, Nitrous Oxide is often used. Nitrous Oxide is a very safe and effective inhalational agent. It has many advantages including high patient acceptance, suitable for all ages, non-allergenic, diminished gag reflex, slight analgesic effect, rapid onset, and a fast recovery. If you have any questions or concerns with the use of Nitrous Oxide, please inform Dr. Dan.

As a parent, our children and their safety are our top priority. To provide the best experience for our patients when treatment is needed, we allow parents to accompany their child in the treatment room. We are aware that your child will always "choose" you when uncomfortable situations arise, such as undergoing dental treatment, if they are nervous. Therefore, we ask that if you choose to accompany your child in the treatment room you act as a "silent observer." Your presence will provide comfort to your child, but it is important that there be an uninterrupted line of communication between Dr. Dan and the patient. This open communication between your child and Dr. Dan will instill trust in the dentist and will boost your child's confidence and ability to address and conquer challenging situations. If being a "silent observer" becomes too difficult and causes an interference in providing the highest level of care, you may be asked to wait in the reception area until treatment is completed. Additionally, if at any point during the procedure you feel uneasy you are welcome to exit the treatment room and wait in the reception area and our staff will accompany your child to you once the treatment is completed.

Operative treatments are only scheduled in the A.M. as children are more attentive and receptive at this time of day.

CONSENT

Your child is a minor; therefore, it is necessary to obtain signed consent from a parent or guardian prior to any necessary dental treatment. **THE PARENT OR GUARDIAN WHO BRINGS THE CHILD FOR DENTAL TREATMENT IS RESPONSIBLE FOR ALL FEES.** We will be glad to provide necessary receipts for reimbursement if another party is responsible for the child's healthcare costs.

I grant the doctor permission to provide my child's dental exam and treatment, including radiographs, study models, photographs, and/or any other diagnostic aid deemed necessary to make a thorough diagnosis, and perform any treatment or therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I will be responsible for all costs associated with 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. If it would be necessary to involve a third party to collect all or any part of an amount owed to Daniel Allen, DMD, MSD, LLC d/b/a Hendricks Pediatric Dentistry, 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:_____

HENDRICKS PEDIATRIC DENTISTRY
DANIEL ALLEN, D.M.D., M.S.D.

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.