CLARK & ASSOCIATES

DENTISTRY

NEW PATIENT REGISTRATION

Patient Name: _____
LAST FIRST MIDDLE

Address: _____
STREET # & NAME CITY STATE ZIP CODE

Home # (_____) _____ Date of Birth: _____/_____/_____ Age: _____ Gender: ❑ M ❑ F

Name of Siblings: _____

PARENT/GUARDIAN INFORMATION

Name: _____ Relationship to child: _____

Date of Birth: _____/_____/_____ Gender: ❑ M ❑ F Social Security Number: _____-_____-_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partnership

Address (if different from above): _____

Email Address: _____

Home # (_____) _____ Cell # (_____) _____ Work # (_____) _____

Name: _____ Relationship to child: _____

Date of Birth: _____/_____/_____ Gender: ❑ M ❑ F Social Security Number: _____-_____-_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Domestic Partnership

Address (if different from above): _____

Email Address: _____

Home # (_____) _____ Cell # (_____) _____ Work # (_____) _____

INSURANCE INFORMATION

Primary Dental Insurance Company Name: _____

Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Employer: _____ ID #: _____ Group #: _____

Secondary Dental Insurance Company Name: _____

Policy Holder: _____ Policy Holder's DOB: _____/_____/_____

Employer: _____ ID#: _____ Group#: _____

I grant Clark and Associates permission to provide dental examination and treatment. I further agree to be responsible for the cost of this dental care. I understand that I am financially responsible for all treatment incurred by my child, including any amounts not covered by my insurance company, interest on unpaid amounts, and reasonable cost of collection efforts should my account become delinquent.

X _____
PARENT/GUARDIAN SIGNATURE DATE

CLARK & ASSOCIATES
DENTISTRY

Child's Name: _____ Date: _____

MEDICAL HISTORY

Please Mark "YES" if your child has a history of the following For each "YES", please provide details in the space provided below.

Seizures/Convulsions/Dizziness/Loss of Consciousness	❑ Yes	❑ No
Cerebral Palsy/Developmental Delay	❑ Yes	❑ No
Social/Cognitive/Mental Delay	❑ Yes	❑ No
Autism/Asperger's Syndrome	❑ Yes	❑ No
ADHD/ADD	❑ Yes	❑ No
Born with/Current Heart Issues	❑ Yes	❑ No
Anemia/Excessive Bleeding/Blood Problems	❑ Yes	❑ No
Asthma/Bronchitis/Pneumonia/Shortness of Breath	❑ Yes	❑ No
Kidney/Bladder Problems	❑ Yes	❑ No
Cancer/Tumor/Leukemia	❑ Yes	❑ No
Hearing Problems/Deaf	❑ Yes	❑ No
Malignant Hyperthermia	❑ Yes	❑ No
Vitamin B-12 Deficiency	❑ Yes	❑ No
Operations/Surgeries	❑ Yes	❑ No

If you answered "YES", please elaborate here: _____

_____

Current Medications: _____

ALLERGIES

Latex	❑ Yes	❑ No	Food	❑ Yes	❑ No
Seasonal	❑ Yes	❑ No	Medication	❑ Yes	❑ No

Reaction(s) _____

Does your child have any other major medical problems we should know about? Please elaborate:

_____

_____

_____

CLARK & ASSOCIATES
DENTISTRY

Child's Name: _____ DOB: _____

DENTAL HISTORY

What is the primary purpose of today's visit? _____

Is today your child's first dental visit? ❑ Yes ❑ No

If yes, who was the child's previous dentist? _____

Date of last visit: _____/_____/_____ Purpose of last visit: _____

Do you believe your child will react well to today's treatment? ❑ Yes ❑ No

What do you think we can do to make your child's visit a positive experience? _____

_____

At the present time, does your child (check all that apply):

- ❑ Use a pacifier
- ❑ Use a sippy cup
- ❑ Suck thumb/fingers
- ❑ Bite nails/chew on objects
- ❑ Have any loose teeth
- ❑ Have a broken filling
- ❑ Take anything to drink to bed (besides water)
- ❑ Tongue thrust
- ❑ Have bleeding gums
- ❑ Lip or cheek biting
- ❑ Grind teeth
- ❑ Mouth breathe
- ❑ Bottle feed
- ❑ Have braces

Dental Routine (check all that apply):

- ❑ Fluoridated toothpaste
- ❑ Fluoridated mouthwash
- ❑ Drink fluoridated water
- ❑ Brushing alone _____ times daily
- ❑ Brushing by parent _____ times daily
- ❑ Dental floss _____ times weekly
- ❑ Fluoride (essential for promoting health of teeth and preventing cavities):
- ❑ X-rays (for diagnosing tooth decay and growth development):

Who referred you to our office? _____

_____
PARENT/GUARDIAN SIGNATURE DATE

_____
DOCTOR SIGNATURE DATE

CLARK & ASSOCIATES
DENTISTRY

OFFICE POLICIES

We are committed to providing you with high quality dentistry and our fees reflect our professional commitment to excellence.

For the convenience of our patients, we accept the following:

PERSONAL CHECKS AND CASH – are always welcome.

BANKCARDS – We accept Visa, Discover, American Express, and Master Card for credit or debit.

INSURANCE – Co-payments will be estimated and due at the time of service. As a courtesy to our patients, we will submit all necessary information and bill your insurance company once. You are responsible for your bill regardless of insurance coverage. Please take the time to understand your policy

Payment and cancellation policies:

NSF CHECKS – There is a $30 fee for all returned checks.

CANCELLATIONS – We require 24-hour notice if you are unable to make your appointment. Failure to contact us, or to arrive for scheduled appointments, may result in a $25 fee or dismissal from our practice

COLLECTIONS – Any fees incurred as a result of turning a delinquent account to collections will be the responsibility of the account holder.

I have reviewed and understand the above policies.

PARENT/GUARDIAN SIGNATURE

DATE

CLARK & ASSOCIATES
DENTISTRY

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____

PRINTED NAME OF PATIENT/GUARDIAN OR REPRESENTATIVE

_____

SIGNATURE DATE

Relationship to Patient (if other that patient): _____

List anyone authorized person(s) that can receive information regarding your child:

Name: _____ Relationship_____ Date: _____

Name: _____ Relationship_____ Date: _____

Name: _____ Relationship_____ Date: _____

This authorization will remain in effect until designated in writing that the above individuals are no longer able to receive information regarding your child.

X _____

SIGNATURE DATE