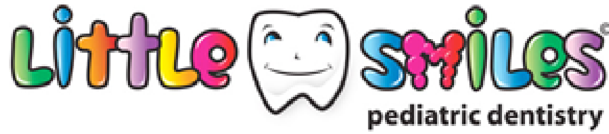


# Registration Form

409 North Peru
Cicero, IN 46034
317-984-1800

Date:

**Tell Us About Your Child**

CHILD'S NAME: Date of Birth:
Address:
Street City State Zip
Home Phone: Sex: M / F
Nickname: School: Grade:

**Who is Accompanying the Child Today?**

Name: Relation to Child:
Do you have legal custody of this child? Yes / No Is the child adopted? Yes / No Is the child in a foster home? Yes / No
Whom may we thank for referring you?
Other sibling's) seen by us:

**Parents**

**Parent's Marital Status:** Married Divorced Separated Widowed Remarried Single

**Mother**

Name: Home Phone:
Address:
Street City State Zip
Social Security #: Date of Birth:
Employer: Work Phone #:

**Father**

Name: Home Phone:
Address:
Street City State Zip
Social Security #: Date of Birth:
Employer: Work Phone #:

**Insurance Information**

**PRIMARY COVERAGE**

*Dental Coverage* yes / no *Orthodontic Coverage* yes / no
Name of Insured: Relation to Child:
Social Security Number of Insured: Date of Birth:
Employer Name: Address:
City State Zip
Insurance Co. Name: Phone #
Insurance Co. Address:
Street City State Zip
Group I.D. #:

**SECONDARY COVERAGE**

*Dental Coverage* Yes / No *Orthodontic Coverage* Yes / No
Name of Insured: Relation to Child:
Social Security Number of Insured: Date of Birth:
Employer Name: Address:
City State Zip
Insurance Co. Name: Phone #
Insurance Co. Address:
Street City State Zip
Group I.D. #:

## Dental History

What is the primary reason for today's visit?

Is the child in pain? Yes / No

Previous / Present Dentist: Date of last visit: Date of last x-rays:

Why did you leave your previous dentist?

Was the previous dental experience positive or negative? Explain

Is the primary source of water consumed be the child fluoridated? Yes / No

Is (was) the child breastfed or bottle-fed? until what age?

How often does your child brush their teeth? Once or twice daily?

How often does your child floss? Zero or once daily?

**Does your child:**

| | | | |
|---|---|---|---|
| Y / N suck thumb / finger | Y / N tongue / cheek chew | Y / N clench / grind teeth | Y / N suck / bite lips |
| Y / N tongue thrust | Y / N breast feed currently | Y / N mouth breathe | Y / N bottle feed currently |
| Y / N use pacifier | Y / N have speech problems or impairment | Y / N bite / chew nails | Y / N trauma to mouth, teeth, or jaw |

## Medical History

Child's Physician: phone: date last seen:

Address:

Street City State Zip

Is the child currently under the care of a physician? Yes / No please explain?

Please list all medications that your child is currently taking:

Please list all drug allergies and / or other reactions:

Is your child pregnant? Due Date? Current on immunizations?

**Has the child had the following:**

| | | | |
|---|---|---|---|
| Y / N abnormal bleeding | Y / N rheumatic fever | Y / N asthma, wheezing | Y / N sensory disorder |
| Y / N anemia | Y / N heart disease | Y / N cerebral palsy | Y / N AIDS / HIV + |
| Y / N blood transfusions | Y / N heart murmur | Y / N cystic fibrosis | Y / N hospital stays/ operations |
| Y / N hemophilia | Y / N congenital heart defect | Y / N epilepsy, seizures, fainting | Y / N cancer/tumors |
| Y / N diabetes | Y / N sickle cell, carrier or trait | Y / N tuberculosis (TB) | Y/ N radiation or chemotherapy |
| Y / N thyroid/endocrine disorder | Y / N headaches, head injury, or loss of consciousness | Y / N kidney problems, urinary tract infections or bed-wetting | Y / N allergies |
| Y / N hepatitis/ jaundice | | | Y / N eating disorder |
| Y / N liver/stomach/intestinal problems | Y / N lung problems | | |

Any history of mental or physical developmental delays?

Any learning, behavioral, or communication problems?

Any history of congenital birth defects?

## Financial Policy

PAYMENT IS DUE AT THE TIME OF SERVICE- The full balance of treatment is due at the time service is rendered. For your convenience we accept cash, check, Care Credit, Master Card, Visa.

Assignment of Dental Insurance Benefits- Our office files insurance benefits as a courtesy. Claims unpaid by your insurance co. after 60 days are your responsibility and will be due in full. All deductibles, co-payments, and non-covered fees are due at the time of service. A CURRENT copy of your insurance card must be kept on file to to utilize this service. Our office reserves the right to discontinue and / or refuse to file claims.

Service Charges- A rebilling fee of $3.00 may be applied to accounts with balances unpaid within 30 days of the statement date. A $25.00 fee will apply to all returned checks. Our office reserves the right to pursue any other remedy by law.

Delinquent Accounts- Account balances that exceed 90 days may be pursued through third party collections. All reasonable expenses incurred in the collection process will become the account holder's responsibility. Delinquent accounts will incur a charge of 8% interest.

**How will you be paying?:** CASH / CHECK / MASTER CARD / VISA / CARE CREDIT

CIRCLE ONE

## Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in my child's medical status. I authorize the dental staff to perform all necessary dental treatment my child may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to Little Smiles Pediatric Dentistry all insurance payments otherwise payable to me.

I understand that I am responsible for the full balance of the account regardless of my dental benefits. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all the above mentioned terms.

Mother

Signature of Parent or Guardian Date

Father

Signature of Parent or Guardian Date

**The parent or guardian who accompanies the child is responsible for the patient at the time of service**