Mendota Dental Associates

Dr. Stephen Sawyer, DDS

CHILDREN REGISTRATION

TODAY'S DATE: _____

PARENT/GUARDIAN NAME: _____

Address:_____ City:_____ State:_____ Zip:_____

Parent Cell Phone #:_____ Home Phone #:_____

Parent Email:_____ Parent Social Security #: _____

CHILDREN UNDER AGE 18:

1. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

2. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

3. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

4. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

5. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

6. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

PRIMARY DENTAL INSURANCE CARRIER *(IF DIFFERENT THAN YOURS)*:

Insurance Carrier: _____

Group #:_____ ID #: _____

Insurance Address: _____

Subscriber: ❑ Self ❑ Other (Name):_____ Date of Birth:_____

Relationship to child:_____ Subscriber's Social Security #: _____

DO YOU HAVE SECONDARY DENTAL INSURANCE? ❑ Yes ❑ No

Secondary Insurance Carrier: _____

Group #:_____ ID #: _____

Insurance Address: _____

Subscriber: ❑ Self ❑ Other (Name):_____ Date of Birth:_____

Relationship to child:_____ Subscriber's Social Security #: _____

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CHILD MEDICAL HISTORY

1. Person completing this form:_____ Relationship to Child: _____

2. **CHILD'S NAME:**_____ Child's Date of Birth:_____

3. Medical Physician's Name/Clinic: _____

Phone Number:_____ Location: _____

4. Has your child had any medical care other than routine visits within the past two years? ❑ Yes ❑ No

If yes, please explain: _____

5. List any medications (and dosage), including over-the-counter and/or herbal remedies:

_____ _____ _____

_____ _____ _____

_____ _____ _____

6. Has your child had any allergic reaction (or adverse) reaction to any substance or medication? ❑ Yes ❑ No

If yes, please explain: _____

7. Has your child been hospitalized within the past five years? ❑ Yes ❑ No

If yes, please explain: _____

8. **GIRLS ONLY:** Is there any chance of pregnancy? ❑ Yes ❑ No If yes, _____ months pregnant

Any use of a birth control prescription? ❑ Yes ❑ No

9. **INDICATE WHICH OF THE FOLLOWING YOUR CHILD HAD OR CURRENTLY HAS:** ***(Check ALL that apply)***

❑ Heart Concerns
❑ Heart Murmur
❑ Rheumatic Fever
❑ Cortisone Medication
❑ Special and/or Restricted Diet
❑ Kidney Problems
❑ Thyroid Problems
❑ Sinus Problems
❑ Diabetes
❑ Artificial Joint (Hip, Knee, etc.)
❑ Emphysema
❑ Chronic Cough
❑ Tuberculosis
❑ Asthma
❑ Allergies/Hay Fever/Hives

❑ Radiation Therapy
❑ Chemotherapy
❑ Tumors
❑ Hepatitis *(circle one)* A B C
❑ AIDS/HIV Positive
❑ Cold Sores/Fever Blisters
❑ Blood Transfusions
❑ Hemophilia
❑ Sickle Cell Disease
❑ Liver Disease/Yellow Jaundice
❑ Neurological Disorders
❑ Bruise Easily
❑ Latex Sensitivity
❑ Epilepsy or Seizures
❑ Fainting or Dizzy Spells

❑ Nervousness/Anxiety
❑ Psychiatric/Psychological Care
❑ ADHD
❑ Autism
❑ Hearing Impaired
❑ Vision Impaired
❑ Cancer (Type) _____
❑ Any other condition, or problem not listed here that we should know about?

Please explain: _____

_____

_____

_____

I understand this information is necessary to provide dental care for me in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider to release such information to you. I agree to notify my doctor of any changes in my health or medications.

√ Parent/Guardian Signature:_____ Date: _____

FOR OFFICE USE ONLY: Employee Signature:_____ Date:_____

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CHILD DENTAL HISTORY

1. Person completing this form:_____ Relationship to Child: _____

2. **CHILD'S NAME:**_____ Child's Date of Birth: _____

3. Previous Dentist's Name/Clinic: _____

Phone Number:_____ Location: _____

4. What is the main reason for your visit today? _____

5. When was the last date your child had the following dental procedures done:

Dental Exam:_____ Dental Cleaning: _____ Full Mouth X-Rays: _____

6. Was anything other than routine dental care done at your child's last dental visit? ❑ Yes ❑ No

If yes, please explain: _____

7. How often has your child had dental exams?_____ Brush their teeth?_____ Floss? _____

8. Has your child ever used or are currently using topical fluoride? ❑ Yes ❑ No

9. What other dental aids does your child use (Interplak, toothpicks, etc.)? _____

10. **INDICATE WHICH OF THE FOLLOWING MAY APPLY TO YOUR CHILD:** ***(Check ALL that apply)***

- ❑ Sensitivity to hot or cold
- ❑ Sensitivity to sweets
- ❑ Biting or chewing problems
- ❑ Mouth odors or bad tastes
- ❑ Frequent cold sores, blisters or other oral lesions
- ❑ Bleeding and/or sore gums
- ❑ Parent's history of gum disease or tooth loss
- ❑ Loose teeth or change in bite
- ❑ Clenching/grinding teeth while awake or asleep
- ❑ Biting their lips or cheeks
- ❑ Food gets caught in between teeth?
- ❑ Hold foreign objects with their teeth (pencil, pipe, etc.)
- ❑ Mouth breathing while awake or asleep
- ❑ Snoring or other sleeping disorders
- ❑ Smoke or chew tobacco or other tobacco products
- ❑ Tired jaws, especially in the morning
- ❑ Clicking or popping of the jaw
- ❑ Pain in their joint, ear, or side of face
- ❑ Difficulty in opening or closing their mouth
- ❑ Difficulty in chewing on either side of their mouth
- ❑ Headaches, neck aches or shoulder aches
- ❑ Sore muscles in their neck or shoulders
- ❑ Nervousness/anxiety about dental treatments

CHECK ALL THAT YOUR CHILD HAS HAD:

- ❑ Orthodontic treatment
- ❑ Oral Surgery
- ❑ Periodontal treatment
- ❑ Teeth ground down or bite adjusted
- ❑ A bite plate or mouth guard
- ❑ A serious injury to their mouth or head

Please explain: _____

_____

11. Is your child required to take a pre-med (antibiotic) before dental visits? ❑ Yes ❑ No

Reason: _____

12. Are you/they satisfied with the appearance of their teeth? ❑ Yes ❑ No

If not, tell us what you'd like to change: _____

13. Would you/they like to replace any existing amalgam (silver-colored) fillings? ❑ Yes ❑ No ❑ Unsure, let's discuss

14. Anything else you'd like us to know regarding your child's dental care? _____

_____

FOR OFFICE USE ONLY: Employee Signature:_____ Date:_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS:

PURPOSE OF CONSENT: By signing this form, you consent to our use of your protected health information to carry out treatment, payment activities and healthcare operations.

NOTICE OF PRIVACY PRACTICES: You have the right to read the Notice of Privacy Practices before you decide whether to sign this consent. Our Notice of Privacy Practices provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your health information, and of other important matters about your protected health information. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change them, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our business manager. Please understand that revocation of this consent will not affect any action we took before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

CONSENT FOR TREATMENT AGREEMENT

1. I *(parent/guardian name)* _____ , hereby authorize Dr. Sawyer and his designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed necessary by Dr. Sawyer to make a thorough diagnosis of my child's dental needs.
2. Upon such diagnosis, I authorize Dr. Sawyer to perform all recommended treatment that has been mutually agreed upon by me, and to employ such assistance as required to provide the proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to Dr. Sawyer or any of his designated staff's use and disclosure of any oral, written, or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree that this Consent for Treatment Agreement will remain active and ongoing for any and all future treatment, until I have asked to end this agreement.

MY CONSENT IS GIVEN FOR THE FOLLOWING CHILDREN:

1. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

2. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

3. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

4. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

5. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

6. Child Name: _____ Date of Birth:_____ ❑ Female ❑ Male

√ Parent Signature:_____ Date:_____

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COMMITMENT TO FINANCIAL AGREEMENT

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance benefits, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy. For your convenience, we offer the following methods of payment.

1. **PAYMENT IN FULL BY CASH, CHECK, OR CREDIT CARD.** Services paid on the day of treatment may be eligible for a savings if no insurance benefits are involved.
2. **PAYMENT BY YOUR DENTAL INSURANCE BENEFITS.** We will file your benefit claim form and accept payment directly from your insurance company, provided that deductibles and any estimated non-covered fees are paid at each appointment. Please note that your benefits are a contract between you, your employer, and your insurance company; We are not a party to that contract; We cannot guarantee your benefits or speak for your insurance company; We can only estimate your benefits. We file claims as a courtesy to you, our valued patient. Please note that you are responsible to pay all fees for services provided to you, regardless or the outcomes of any benefit claim that we file on your behalf.
3. **THIRD PARTY FINANCING WITH CARECREDIT.** You may apply for a line of credit and make monthly payments to CareCredit. You may visit www.CareCreditPro.com for more information and to apply.

THE AMOUNT DUE FOR TREATMENT MUST BE PAID ON THE DATE OF TREATMENT.

An interest charge of 1.5% per month will be charged to any unpaid balance after 60 days. Please understand that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered for that child. We cannot bill another party on your behalf. By signing, you agree to pay all costs of collections that may occur, including but not limited to interest, attorney or collection agency fees.

√Parent Signature:_____ Date:_____

CANCELLATION POLICY WITH MENDOTA DENTAL

1. The appointments you make with our doctor and dental team are reservations and are considered a commitment to your dental health and our business relationship with you. Failed appointments are a disappointment to everyone involved, including you, our doctors, dental team, and other patients in need of dental treatment.
2. When patients do not show for their scheduled appointments or do not give us adequate cancellation notice, we are not given the opportunity to reschedule that time with other patients who do have a true dental need.
3. **We ask for a 48-hour notice for cancellations.** Failed or cancelled appointments with less than 48-hour notice may have a cancellation fee of $25 for every 30 minutes of scheduled appointment time that was reserved for you.
4. Any patient that fails to show up for their scheduled appointments without any notice three (3) or more times, or continues to cancel their appointments without 48-hour notice, **may be dismissed from our office.** It is very important to us to be able to maintain available times for all patients.

√Parent Signature:_____ Date:_____