Calabasas Pediatric Dentisty & Orthodontics

Patient Registration Form

CONTACT INFORMATION			
Home Address:			
Home Telephone:			
PATIENT INFORMATION			
CHILD 1	First Name:	Last Name:	School:
	Age:	Birthday: / /	Sex: M F
CHILD 2	First Name:	Last Name:	School:
	Age:	Birthday: / /	Sex: M F
CHILD 3	First Name:	Last Name:	School:
	Age:	Birthdate: / /	Sex: M F

PARENT INFORMATION	
PARENT 1	PARENT 2
Martial Status: Single Married Divorced Widowed	Martial Status: Single Married Divorced Widowed
Name:	Name:
Birth date: / /	Birth date: / /
Address (if different):	Address (if different):
Occupation:	Occupation:
Employer:	Employer:
Business Phone:	Business Phone:
Cell Phone:	Cell Phone:
Email:	Email:

May we email or text you to confirm your child's appointment? ☐ YES ☐ NO

INSURANCE INFORMATION	
Primary Coverage	Secondary Coverage (if applicable)
Insurance Carrier:	Insurance Carrier:
Subscriber Name:	Subscriber Name:
Social Security:	Social Security:

Name of person responsible for account:______________________________

****Please present your DENTAL insurance card on your initial visit & if you have changed insurance coverage recently****

REFERRAL HISTORY

Whom may we thank for referring you?

☐ Family ☐ Friend:___________________

☐ Ins. Plan ☐ Dr.:______________________

☐ Internet:______________________________

☐ School visit by doctor @_________________________

☐ Other:________________________________

I authorize Dr. Rumack to perform the necessary dental service my child may need for his/her well-being. I also authorize Dr. Rumack to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners.

I request that my insurance company pay directly to Dr. Rumack, and I understand that my insurance carrier may pay less than the actual bill for service; therefore, I agree to be responsible for payment of all services rendered on my child's behalf. I authorize the use of this signature on all my insurance submissions.

Parent/Legal Guardian (PRINT):____

Parent/Legal Guardian (Signature):_____________________________________ Date:________________

Calabasas Pediatric Dentistry & Orthodontics

MEDICAL HISTORY

Patient Name:

Birthdate: / / Age: Sex: M F

Patient Physician: Phone:

Is/Has your child: **Y N**

Immunizations current? If no, please explain:______________________________

Any illnesses now? Type:______________________________

Taking any medications? List:______________________________

Ever been hospitalized? Specify:______________________________

Ever had surgery? Specify:______________________________

My Child is allergic to: **Y N**

MEDICATIONS: List______________________________

LATEX: Specify:______________________________

OTHER ALLERGIES: List:______________________________

Has/Had any history of:	**Y**	**N**		**Y**	**N**		**Y**	**N**
ADD/ADHD			Down Syndrome			HIV/AIDS		
Anemia			Developmental Delay			Kidney Disease		
Asthma			Diabetes			Liver Disease		
Autism			Eye Problems			Mental Disturbances		
Bleeding Disorder			Fainting/Dizziness			Muscular Dystrophy		
Blood Transfusion			Frequent Ear Infections			Orthopedic Problems		
Brain Injury			Hearing/Speech Problems			Rheumatic Fever		
Bruising Easily			Heart Murmur			Sleep Apnea		
Cerebral Palsy			Heart Problems			Tonsil Problems		
Chronic Headaches			Hepatitis			Tuberculosis		
Convulsions/Seizures			Hyperactivity			Tumors/Cancer		

Special Needs/Other:______________________________

DENTAL HISTORY

Reason for this appointment: ______________________________

Please specify any dental and/or orthodontic concerns:______________________________

Name of previous dentist:______________________________

Last dental visit date: / / Last X-rays were taken on: / /

Has Child had experience with:	**Y**	**N**		**Y**	**N**		**Y**	**N**
Dental pain in the past?			**Adverse reactions to:**			> Nail biting		
Fillings or extractions?			> Dental anesthetics?			> Grinding teeth		
Sealants applied?			> Any dental materials?			> Lip sucking/ biting		
Fluoride supplements?			**Dental Habits:**			> Mouth breathing		
Dental injuries?			> Thumb sucking			> Sleeping with a bottle		
Dental sedation?			> Pacifier usage			> Tongue thrust		

Has your child ever had an unhappy dental experience, please explain:______________________________

How would you describe your child's previous dental experience?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Parent/Legal Guardian (PRINT):______________________________

Parent/Legal Guardian (SIGNATURE):______________________________ Date:______________

OFFICE POLICIES FOR PEDIATRIC DENTISTRY AND ORTHODONTICS

Welcome to our Practice! We are delighted that you have chosen our office to care for your children's dental needs. Our primary goal is that your children receive the optimal care needed to restore and maintain their oral health. It is the intention of the following office polices to assist in making your treatment as pleasant and efficient as possible. Please help us help you! Thank you!

Payment Charges:

All new and current patients will be required to pay the estimated patient portion for dental treatment the day that services are rendered. We accept cash, personal checks, and for your convenience MasterCard, American Express, Visa and Discover. Your time is valuable as well as the doctor's. That is why we strive to take patients on a timely matter. If you are unable to keep your appointment, please give us a 24-48 hour notice. Failure to do so will result in a $65 dollar cancellation fee. Any late appointments may have to be rescheduled, and a broken appointment fee of $65 may be applied for re-occurring offenses.

Insurance:

Our office is committed to helping you maximize your insurance benefits. We will do our best to assist you in billing your insurance company. Please understand that your insurance policy is a contract between you and your insurance company. **IT IS YOUR RESPONSIBILITY TO KNOW IF OUR OFFICE IS PARTICIPATING OR NON-PARTICIPATING WITH YOUR INSURANCE PLAN. AS OF APRIL 20, 2017 THIS OFFICE IS ONLY IN-NETWORK WITH DELTA DENTAL PREMIER, BLUE SHIELD OF CA, AND CIGNA – PLEASE KEEP IN MIND THAT OUR CONTRACT WITH ANY OF THE LISTED INSURANCES MAY BE DROPPED AT ANY TIME. BECAUSE INSURANCE PLANS VARY, WE CAN ONLY ESTIMATE YOUR COVERAGE IN GOOD FAITH, BUT CANNOT GUARANTEE COVERAGE DUE TO THE COMPLEXITIES OF INSURANCE CONTRACTS**. Your estimated patient portion, along with unpaid deductibles, must be paid at the time of service. As a service to our patients, we will bill insurance companies and allow them 45 days to render payment. After 60 days, you are responsible for the entire balance, paid-in-full. If you have any questions, please call our office and we will be happy to assist you.

Overdue accounts:

Balances older than 90 days may be subject to additional collection fees and finance charges if such actions become necessary. Returned checks will have an additional fee of $35.00 added to the amount of the returned check. We encourage you to communicate any such problems to us so that we can assist you in the management of your account. However, our office will bill you directly for any outstanding balances. It is your responsibility to keep your mailing address and phone numbers updated to help keep your account current.

Parents:

Our office asks that a parent or guardian be present during the dental visit. Again, thank you for choosing Calabasas Pediatric Dentistry & Orthodontics to care for your children. We do not take for granted the precious children you entrust us with. We appreciate the opportunity to care for them!

By signing below, I acknowledge that I am the parent or legal guardian of ____________________

____.

I have read and understood the office polices and agree to adhere them. I also understand that my signature below serves as an assignment for the purposes of any insurance reimbursement in which case, I understand it may be sent to the office.

Signature_____________________________Relationship______________________Date___________

CALABASAS PEDIATRIC DENTISRTY & ORTHODONTICS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

*** You May Refuse to Sign This Acknowledgement***

I, ______________________________, have received a copy of this office's Notice of Privacy Practice

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers interfered with obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (Please Specify)

Release of Records

I authorize the office of Dr. Elena Rumack and Dr.Lecia Harmer to receive a copy of my child's/children's complete dental records, including any x-rays, to be sent to:SMILES@CALABASASTOOTHFAIRY.COM

Please attach this form with requested information to the email. Thank you!

Child #1 Name:____
Date of Birth: ______________________
(For previous office use only)
Last Prophy: ______________________
Last x-rays: _______________________
Filling history: ____
Sealant history: ____

Child #2 Name:____
Date of Birth:_______________________
(For previous office use only)
Last Prophy: ______________________
Last x-rays: _______________________
Filling history: ____
Sealant history: ____

Child #3 Name: _______________________________________
Date of Birth:_______________________
(For previous office use only)
Last Prophy: ______________________
Last x-rays: _______________________
Filling history: ____
Sealant history: ____

Child's Previous Dentist/Office: ____
Parent/Legal Guardian Name:____
Signature:____ **Date:** ___________________