

# Pediatric Dentistry of Prospect

Jeffrey G. Crenshaw D.M.D.

## REGISTRATION FORM

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

Patient's SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M F

Home Address: \_\_\_\_\_  
Street Address State Zip Code

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Do we see other children in your family? \_\_\_\_\_ Names: \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

What is the reason for your child's dental visit? \_\_\_\_\_

### PARENT / GUARDIAN INFORMATION

1) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

Address (if different from child): \_\_\_\_\_  
Street Address State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ May we send email appointment reminders? Yes No  
\*\*\*\*\*

2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Employer: \_\_\_\_\_

Address (if different from child): \_\_\_\_\_  
Street Address State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ May we send email appointment reminders? Yes No

### INSURANCE INFORMATION

#### \*\*Primary Dental Insurance\*\*

Policy Holder's Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

#### \*\*Secondary Dental Insurance\*\*

Policy Holder's Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy ID: \_\_\_\_\_ Group Number: \_\_\_\_\_

Person responsible for payment: \_\_\_\_\_

Emergency Contact (other than parent):

\_\_\_\_\_  
Name Relationship Phone #

# MEDICAL/DENTAL HISTORY

Physician's Name \_\_\_\_\_ Physician's Phone Number \_\_\_\_\_

- Yes  No Is your child in good health?  
Date of last physical examination: \_\_\_\_\_
- Yes  No Is your child taking any medications? Please give and reason \_\_\_\_\_
- Yes  No Is your child allergic to any medications? \_\_\_\_\_
- Yes  No Is your child allergic to anything (milk, grass, etc...)? \_\_\_\_\_
- Yes  No Has your child had surgery/hospitalizations? Please give reason and date \_\_\_\_\_
- Yes  No Are your child's immunizations up to date? \_\_\_\_\_

Please check if your child has or has had any of the following:

- |  |  |   |  |   |
|--|--|---|--|---|
| <b><u>Cardiovascular</u></b><br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Heart Murmur<br><input type="checkbox"/> Mitral Valve Prolapsed<br><input type="checkbox"/> Rheumatic Fever<br><input type="checkbox"/> Other Heart Problem | <b><u>Hematologic</u></b><br><input type="checkbox"/> Blood Transfusion<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> HIV/AIDS<br><input type="checkbox"/> Hemophilia<br><input type="checkbox"/> Leukemia<br><input type="checkbox"/> Sickle Cell Anemia<br><input type="checkbox"/> Other Blood Disorders | <b><u>Neurologic</u></b><br><input type="checkbox"/> Vision Problems<br><input type="checkbox"/> Hearing Loss<br><input type="checkbox"/> Epilepsy/Seizures<br><input type="checkbox"/> Severe Headaches<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Cerebral Palsy<br><b><u>Endocrine</u></b><br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Thyroid Disease<br><input type="checkbox"/> Taking Steroids or Cortisone | <b><u>Genitourinary</u></b><br><input type="checkbox"/> Kidney Transplant<br><input type="checkbox"/> Urinate Frequently<br><input type="checkbox"/> Other Kidney/Bladder<br><input type="checkbox"/> Problem<br><b><u>Dermal/</u></b><br><b><u>Musculatory</u></b><br><input type="checkbox"/> Latex Allergy<br><input type="checkbox"/> Skin Rash<br><input type="checkbox"/> Rheumatoid Arthritis | <b><u>Gastrointestinal</u></b><br><input type="checkbox"/> Hepatitis<br><input type="checkbox"/> Liver Disease<br><br><b><u>Other Conditions</u></b><br><input type="checkbox"/> Frequent Sore Throat<br><input type="checkbox"/> Tobacco Use<br><input type="checkbox"/> Cleft Lip/Palate<br><input type="checkbox"/> Radiation Therapy<br><input type="checkbox"/> Chemotherapy<br><input type="checkbox"/> Condition/Problem<br>Not Listed |
|--|--|---|--|---|

**Syndrome:** \_\_\_\_\_

If you checked any of the above, please explain \_\_\_\_\_

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

Name of previous dentist: \_\_\_\_\_ Date of last visit/x-rays: \_\_\_\_\_

Has your child had any unfavorable dental experiences:  Yes  No Explain \_\_\_\_\_

How often does your child brush his/her teeth? \_\_\_\_\_ Floss? \_\_\_\_\_ Does anyone help?  Yes  No

Does your child use a fluoridated toothpaste?  Yes  No

Is your home water supply fluoridated?  Yes  No

Do you give your child any other form of fluoride?  Yes  No What? \_\_\_\_\_

Has your child ever, had injury to his/her face or mouth?  Yes  No Describe \_\_\_\_\_

Are there any mouth habits (finger/thumb sucking, pacifier, tongue thrusting, teeth grinding, mouth breather, other)? \_\_\_\_\_

What age was the bottle/breast feeding discontinued? \_\_\_\_\_

Does your child use a "sippy" cup?  Yes  No

Does your child eat frequent snacks between meals?  Yes  No

Does your child drink milk/soda/juice between meals?  Yes  No

Do you expect your child to cooperate for the exam?  Yes  No

I hereby acknowledge that the information provided above is true representation of my child's medical and dental history/condition.

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Appointment and Cancellation Policy

## Pediatric Dentistry of Prospect

**One** parent is permitted to remain with each child during treatment. Dr. Crenshaw will discuss with you the terms and conditions of this privilege. Other guests/siblings must remain in the reception room.

\*\*\*\*\*

Pediatric Dentistry of Prospect excels in providing a timely visit for you and your child. We keep an accurate schedule for our busy families to ensure your wait in our office will be brief. We request our patients arrive 10 minutes early for their scheduled appointment. Your appointment will be considered "missed" if you arrive more than 10 minutes late and you may be asked to reschedule. **If you need to cancel or reschedule your appointment, a 24 hour notice is required. If you miss your scheduled appointment without giving us the required notice, your child may be placed on our "Day of Only" policy (advance appointments are not given). If two or more missed appointments occur, your child may be dismissed from our practice.**

\*\*\*\*\*

**I have read and fully understand the above appointment and cancellation policies and accept all provisions.**

Patient's Name: \_\_\_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Relationship: \_\_\_\_\_

# Assignment of Benefits Agreement

## Pediatric Dentistry of Prospect

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following financial provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the co-payment and/or deductible, which is the amount not covered by your insurance, prior to any service your child may receive.
- Our Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our office. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to sort out any questions. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

**I have read and understand the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Pediatric Dentistry of Prospect.**

Patient's Name: \_\_\_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

# Financial Policy

## Pediatric Dentistry of Prospect

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance is not received within 60 days from the date of billing/service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims, regardless of whether our office is a provider for your insurance company. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file an insurance claim, you must bring to us a dental insurance form proof of insurance to be kept on file.

Payment is due at the time service is provided. Our office accepts personal checks, MasterCard, and Visa.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Any returned checks will be assessed a \$25.00 charge. Since your bank must, by law, inform you of a dishonored check, we will expect you to contact us to make arrangements for settling the full amount of the check plus \$25.00, within ten (10) days. Late payment charges will be assessed if the matter is not settled by that time. Additionally, our office will charge you a minimum of \$20.00 for broken appointments cancelled without a 24-hour advanced notice.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

**I have read and fully understand the above financial policy and accept all provisions.**

Patient's Name: \_\_\_\_\_

Parent's/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

# Consent for Dental Treatment/Treatment Plan

## Pediatric Dentistry of Prospect

**\* Please read this form carefully before your visit and sign at your visit.\* If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it!**

### Permission To Treat:

Since your child is a minor, it becomes necessary that signed permission be obtained from the parent or legal guardian for any and/or all necessary dental services.

1. I request and authorize the treatment and procedures outlined on the Treatment Plan for:

**Patient Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

2. I further request and authorize the taking of dental radiographs (x-rays) and the use of such anesthetics or nitrous oxide (“laughing gas”) as may be considered necessary to treat my child’s dental condition(s).
3. I have had explained to me by Dr. Crenshaw or his associates, and have had sufficient opportunity to discuss my child’s dental condition(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatments.
4. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include, but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness and allergic reactions.
5. I understand that during the course of my child’s dental treatment, something unexpected may arise that may necessitate procedures in addition to or different than those listed on the Treatment Plan and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledges that no guarantees have been made to me concerning the results of the dental treatment that my child receives at Pediatric Dentistry of Prospect.
6. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.
7. I understand that should my child become uncooperative during dental treatment with movement of the head, arms, and or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold my child’s hands, stabilize the head and/or control leg movement.
8. I further understand that should my child become uncooperative during dental procedures with excessive body movements, my child may need to be wrapped in a “huggy blanket” or “papoose board” to prevent injury and enable Dr. Crenshaw and/or his associates to safely provide the necessary treatment.
9. For the purpose of advancing medical/dental education, I give permission for the use of clinical radiographs and photographs of my child for diagnostic, scientific, educational or research purposes.
10. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures outlined on the Treatment Plan.
11. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
12. I confirm that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

Patient’s Name: \_\_\_\_\_

Parent’s/Guardian’s Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

# Fluoride Policy

Patient name: \_\_\_\_\_

Fluoride plays an important role in keeping teeth healthy by preventing tooth decay. Fluoride treatments are a routine part of dental cleanings. Fluoride helps strengthen enamel (the translucent material that covers your teeth). Stronger enamel helps minimize the effects of demineralization-the loss of minerals caused by the damaging acid that bacteria in plaque produce.

Our office uses a strong concentration of fluoride which we brush onto the teeth for a more even coverage. We prefer this method over the "swish and spit" method you may remember as a child. Dr. Crenshaw recommends fluoride treatment every 6 months for all children.

Insurance coverage varies between insurance companies and policies. If you are unsure of your insurance coverage for fluoride, please ask a receptionist and she will be happy to give you the information. Some insurance will pay for the procedure every six months. Others only pay once a year.

Fluoride \$27.00

Please initial your choice below:

\_\_\_\_\_\* I would like my child to receive fluoride treatments every 6 months. I understand if my insurance does not cover this procedure, I will be billed.

\_\_\_\_\_\* I would like my child to receive fluoride only if it is a covered benefit under by insurance policy.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_