GULF COAST pediatric dentistry
MAEGEN MCCABE, DMD

New Patient Registration

Child/Children's Names: _____

_____

_____

Parent(s)/Legal Guardian Name: Mr./Mrs./Ms./Dr.:_____

Who has Legal Custody? ☐Mom ☐Dad ☐Both ☐Other:_____

Address:_____City:_____State:_____Zip:_____

Preferred Communication Method: ☐Home Phone ☐Cell Phone ☐Text Message ☐Email

Phone Numbers-Home: (___) ___-____ Cell: (___) ___-____ Work: (___) ___-____

Email Address:_____How did you hear about us?:_____

Person responsible for payment of account:_____SS#:_____DOB:_____

Is your child covered under any dental insurance? ☐Yes ☐No

If YES:

What dental insurance company?_____ ID #:_____

Name of policy holder:_____ Employer:_____

Policy holder SS#:___-___-____ Policy holder birthday:___/___/____ Relation:_____

If there are other persons you would like to give permission to bring your child/children to Gulf Coast Pediatric Dentistry and to make dental treatment decisions on your behalf, please list:

_____ _____

Name of Person Relationship to Child

_____ _____

Name of Person Relationship to Child

Please sign below if you agree to the following statements:

1. I attest that the above information is true to the best of my knowledge. I hereby authorize the dentist or dental auxiliaries under her supervision, to perform any necessary dental treatment upon my child/children listed above, including but not limited to the use of x-rays, topical fluoride, local anesthetic, and/or Nitrous Oxide. I will allow photographs to be taken of my child or child's teeth for diagnostic, education, or marketing purposes.
2. I have received, read, and fully understand Gulf Coast Pediatric Dentistry's Financial Policy and Appointment Cancellation policy and I accept all provisions. I am responsible for any charges incurred for dental treatment on the child/children listed above.
3. I have received, read, and fully understand Gulf Coast Pediatric Dentistry's Assignment of Benefits Agreement and authorize my insurance company (if any) to pay by dental benefits directly to Gulf Coast Pediatric Dentistry.
4. I have received, read, and fully understand Gulf Coast Pediatric Dentistry's Notice of Privacy Practices. I understand that I may refuse to sign this acknowledgement if I do not agree.

_____ _____ _____

Signature of parent/guardian Relationship to Child Date

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New Patient History Intake Form

Child's Full Name:_____ Nickname:_____ Age:_____

Birthday:_____/_____/_____ Grade:_____ Gender: ☐Male ☐Female Race:_____ Weight:_____

Medical History

Name of child's physician:_____ Date of last physical exam:_____

Is your child being treated by a physician at this time? Reason:_____ ☐Yes ☐No

Is your child taking any medication (prescription or OTC) vitamins, supplements? ☐Yes ☐No
List name, dose, frequency:_____

Has your child ever been hospitalized? Reason:_____ ☐Yes ☐No

Is your child allergic to anything? List:_____ ☐Yes ☐No

Please check if your child has a history of any of the following conditions:

☐ADHD	☐Diabetes	☐Mental delays
☐Adverse drug reactions	☐Ear &/or tonsil surgery	☐Physical delays
☐AIDS/HIV	☐Endocrine/growth	☐Premature birth
☐Anemia	☐Eyesight	☐Psychological disorders
☐Artificial Valve/Joint	☐GI disease (including reflux)	☐Rheumatic Fever
☐Asthma or breathing issues	☐Heart condition/murmur	☐Seizures/epilepsy/fainting
☐Autism	☐Hepatitis	☐Sickle Cell Anemia
☐Blood disorders	☐High/low blood pressure	☐Significant injuries
☐Cancer/tumors	☐Hives/rash/skin problems	☐Sleep apnea/snoring
☐Cerebral palsy	☐Kidney disease	☐Tuberculosis
☐Cleft lip/palate	☐Liver disease	☐Other:_____.
☐Congenital birth defects	☐Measles/mumps	

Please elaborate on any items checked:_____

_____

_____

Dental History

Has your child ever been to the dentist? Name of dentist & date:_____ ☐Yes ☐No

Has your child experienced any unfavorable reaction during previous dental treatment? ☐Yes ☐No
If yes, please explain:_____

Does your child suck a finger, thumb, pacifier or other oral habits?_____ ☐Yes ☐No

Does your child currently have dental pain?_____ ☐Yes ☐No

Do you have any specific concerns relating to your child's teeth?_____ ☐Yes ☐No

How often are your child's teeth brushed?_____ By whom?_____ Fluoride toothpaste? ☐Yes ☐No

What is the source of your child's drinking water? ☐Public Water ☐Well Water

I acknowledge that this information is correct, and I understand withholding medical/dental information can be harmful to my child during treatment.

_____ _____ _____

Signature of parent/guardian | Relationship to Child | Date

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Gulf Coast Pediatric Dentistry to use and disclose protected health information (PHI) about me and/or my child/children to carry out treatment and financial transactions regarding my account. There is a more complete description of such uses available upon request.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Gulf Coast Pediatric Dentistry reserves the right to revise its Notice of Privacy Practices at any time.

By signing this form, I am consented to Gulf Coast Pediatric Dentistry's use and disclosure of my child's/children's PHI to carry out appointment reminders, insurance items, account transactions/information and any calls/emails/faxes pertaining to my child's/children's dental care. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I did not sign this consent or later revoke it, Gulf Coast Pediatric Dentistry may decline to provide treatment to you/your child.

Name of your child/children:_____

_____ _____ _____
Signature of parent/guardian Relationship to Child Date

FINANCIAL AGREEMENT

Payment: Payment in full is due at the time of services unless prior financial agreements have been made. We offer several payment options including: cash, check, debit cards, Visa, MasterCard, American Express, and Discovery. There is a $40.00 fee for returned checks.

Insurance: Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to all our patients, we will be happy to manage all claim submissions and follow up on your behalf.

Fillings: Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance may not pay for a resin filling at the *same level* as a "silver"(amalgam) filling. You are responsible for the difference in cost. In some cases, the dentist may recommend a silver crown (stainless steel crown) instead of a white composite resin filling if a cavity or defect is too large for a filling.

Nitrous Oxide: Nitrous oxide or "laughing gas" is a very safe and reversible mild sedative and pain reliever used routinely in Pediatric Dentistry. Nitrous Oxide is not usually covered by dental insurance. We thank you for your payment on the date of service. (You will be informed if we need to use Nitrous Oxide, and your specific consent will be obtained for its use).

Fluoride and Sealants: Fluoride and Dental Sealants are two of our best weapons against cavities. We may recommend fluoride treatments more or less often than your insurance covers based on your child's risk for cavities. We may also recommend sealants for teeth, based on their risk for developing cavities, and some may not be covered by your insurance. Please review your insurance be

Missed Appointments: Once an appointment has been made, that time is reserved specifically for your child. We reserve the right to charge a $35 fee for a no show appointment or last minute cancellation. We do ask that you give us at least 24 hours notice of cancellation. ***Two missed/broken appointments for a prophy/exam appointment or one missed/broken appointment for treatment visits/oral sedation visit/hospital calls, without at least 24 hrs prior notification, may prevent further scheduling by this office.***

Name of your child/children:_____

_____ _____ _____
Signature of parent/guardian Relationship to Child Date