

Children's
Oral
Care
Only_{PC}

5530 W. Montrose
Chicago, Illinois 60641
(773) 282-8800

185 N. Milwaukee Ave.
Lincolnshire, IL 60069
(847) 478-8100

CHILD'S REGISTRATION AND HISTORY

PATIENT INFORMATION

DATE: _____

NAME: _____ LAST FIRST M MARRIED SINGLE MINOR MALE FEMALE

ADDRESS: _____ STREET APT. # CITY STATE ZIP

BIRTHDATE: _____ MO DAY YR. TELEPHONE: _____ HOME _____ OFFICE

PLACE OF EMPLOYMENT (OR SCHOOL): _____ GRADE _____ S.S. # _____

DENTAL INSURANCE CO.: _____ GROUP NO. _____

Has any member of your family ever been treated in our office? YES NO

Whom may we thank for referring you to our office? _____

WHAT IS CHILD'S FAVORITE SPORT _____ FAVORITE TOY _____

FAVORITE HOBBY _____ FAVORITE PERSON _____ FAVORITE FICTION CHARACTER _____

E-MAIL _____

FAMILY INFORMATION

GUARANTOR

SPOUSE

Name:

Address:

Telephone #:

Birthdate/SS #:

Employer:

Dental Insurance Co.:

Group #:

<p>_____ <small>LAST FIRST M</small></p> <p>_____ <small>STREET CITY STATE ZIP</small></p> <p>_____ <small>HOME # WORK #</small></p> <p>_____ <small>MO DAY YR SS #</small></p> <p>_____ <small>EMPLOYER</small></p> <p>_____ <small>DENTAL INSURANCE GROUP #</small></p>	<p>_____ <small>LAST FIRST M</small></p> <p>_____ <small>STREET CITY STATE ZIP</small></p> <p>_____ <small>HOME # WORK #</small></p> <p>_____ <small>MO DAY YR SS #</small></p> <p>_____ <small>EMPLOYER</small></p> <p>_____ <small>DENTAL INSURANCE GROUP #</small></p>
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PERSON RESPONSIBLE FOR ACCOUNT

CHECK ONE:

Patient Father (or Husband) Mother (or Wife) Guardian

PERSON TO CONTACT OUTSIDE OF IMMEDIATE FAMILY IN CASE OF EMERGENCY

NAME _____ LAST FIRST M TEL # _____

ADDRESS _____ STREET CITY STATE ZIP

DENTAL HISTORY

Date of last visit to a dentist _____
 For what service _____

 Has child complained about dental problems _____

 Any unhappy dental experiences _____

 Any injuries to mouth - teeth - head _____

 Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____

 Any unusual speech habits _____

 Any lost teeth _____

YES NO

Does your child brush teeth daily _____
 Do you assist child with tooth brushing _____
 How often _____
 Is dental floss used _____
 How often _____
 Are disclosing tablets used _____
 Is fluoride taken in any form _____

 Child's attitude to dentistry _____

 Do you desire complete dental service for the child _____

 Have missing teeth been replaced _____

 Orthodontic appliances worn now or ever been _____

YES NO

HEALTH HISTORY

Child's Physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

YES NO

YES NO

Is child under care of physician now _____

 Is child receiving any medication or drugs _____

 Is there any excessive bleeding when cut _____

 Has child ever been hospitalized _____

 Has child ever had surgery _____

 Does child have good physical coordination _____

 Are there any emotional problems _____

 Is there any allergy to penicillin or other drugs _____

 Are there other allergies: food - pollen - animals - dust - other _____

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

- | | | | | |
|---|--|---------------------------------------|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Sinus | <input type="checkbox"/> Hearing | <input type="checkbox"/> Mastoid | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Heart | <input type="checkbox"/> Measles | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Mumps | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Malignancies | <input type="checkbox"/> Rheumatic Fever | |

 Patient Signature (Parent if minor)

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20__.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: CHILDREN'S ORAL CARE ONLY
CAROLINE SCHOLTZ, D.D.S., M.S.
Address: 185 N. MILWAUKEE AVE. STE 140
LINCOLNSHIRE, IL 60069
City/State/Zip: _____