RF | RICHARDS FRANKEL DENTISTRY

Dentistry designed for health and well being.

CHILD'S REGISTRATION

1. Date _____
2. Child's Name _____
3. Nickname _____
4. Age _____
5. Date of Birth _____
6. School _____
7. Grade _____
8. Residence Address _____
9. City/State/ZIP Code _____
10. Father's Name _____
    - Social Security Number _____
    - Employer _____
    - Home Phone _____
    - Business Phone _____
11. Mother's Name _____
    - Social Security Number _____
    - Mother's Employer _____
    - Home Phone _____
    - Business Phone _____
    - Email Address _____
12. Person Financially Responsible (If other than parent)
    - Relationship to Child _____
    - Address _____
    - City/State/Zip Code _____
    - Phone _____
    - Email Address _____
13. Do you have dental insurance coverage _____ Ⓨ Ⓝ
    - Name of Insured _____
    - Social Security Number _____
    - Date of Birth of Insured _____
    - Name of Insurance Company _____
    - Phone Number of Insurance Company _____
    - ID Number of Insured _____
    - Group Number of Insured _____
14. How did you hear about us _____
15. What is your child's favorite hobby _____
16. What is your child's favorite toy _____

CHILD'S DENTAL HISTORY

17. Date of last visit to a dentist _____
    - What service _____
18. Has your child complained about pain in his or her mouth __ Ⓨ Ⓝ
    - If so, please explain _____
19. Any unhappy past dental experiences _____ Ⓨ Ⓝ
    - If so, please explain _____
20. Any injuries to mouth, teeth or head _____ Ⓨ Ⓝ
    - If so, please explain _____
21. Any mouth habits, such as thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____ Ⓨ Ⓝ
    - If so, please explain _____
22. Any unusual speech patterns _____ Ⓨ Ⓝ
    - If so, please explain _____
23. Any lost teeth _____ Ⓨ Ⓝ
24. Is the child under the care of an orthodontist _____ Ⓨ Ⓝ
25. Does your child brush teeth daily _____ Ⓨ Ⓝ
    - How often _____
    - Do you assist child with tooth brushing _____
26. Is dental floss used _____ Ⓨ Ⓝ
    - How often _____
27. Is fluoride take in any form _____ Ⓨ Ⓝ
28. Child's attitude toward dentistry _____

DOCTOR'S SUMMARY

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CHILD'S HEALTH HISTORY

1. Child's Physician _____
   - Address _____
   - Phone _____
2. Date of last physical examination _____
   - Results _____
3. Is your child under care of physician now _____ Ⓨ Ⓝ
   - If so, please explain _____
   - Physician's Name _____
   - Physician's Phone Number: _____
4. Is your child receiving any medication or drugs _____ Ⓨ Ⓝ
   - If so, please explain _____
5. Is there any prolonged bleeding when cut _____ Ⓨ Ⓝ
6. Has your child ever been hospitalized _____ Ⓨ Ⓝ
   - If so, please explain _____
7. Has your child ever had surgery _____ Ⓨ Ⓝ
   - If so, please explain _____
8. Allergies to penicillin or other drugs _____ Ⓨ Ⓝ
9. Allergies food, pollen, animals, dust, etc. _____ Ⓨ Ⓝ
   - If so, please explain _____
10. Does your child have good physical coordination _____ Ⓨ Ⓝ
11. Are there any emotional or psychological problems _____ Ⓨ Ⓝ
    - If so, please explain _____
12. Has child any history of or difficult with any of the following
    - ADD/ADHD _____ Ⓨ Ⓝ
    - Asthma _____ Ⓨ Ⓝ
    - Cancer _____ Ⓨ Ⓝ
    - Cerebral Palsy _____ Ⓨ Ⓝ
    - Chicken Pox _____ Ⓨ Ⓝ
    - Chronic Ear Infections _____ Ⓨ Ⓝ
    - Chronic Sinus Inflammation _____ Ⓨ Ⓝ
    - Convulsions _____ Ⓨ Ⓝ
    - Diabetes _____ Ⓨ Ⓝ
    - Epilepsy _____ Ⓨ Ⓝ
    - Fainting _____ Ⓨ Ⓝ
    - Hearing Disorder _____ Ⓨ Ⓝ
    - Heart _____ Ⓨ Ⓝ
    - Kidney _____ Ⓨ Ⓝ
    - Liver _____ Ⓨ Ⓝ
    - Mastoiditis _____ Ⓨ Ⓝ
    - Measles _____ Ⓨ Ⓝ
    - Mononucleosis _____ Ⓨ Ⓝ
    - Mumps _____ Ⓨ Ⓝ
    - Rheumatic Fever _____ Ⓨ Ⓝ
    - Thyroid Problems _____ Ⓨ Ⓝ
    - Tuberculosis _____ Ⓨ Ⓝ
    - Other _____ Ⓨ Ⓝ
13. Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information the doctor should be aware of that has not been discussed. _____

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Handle My Child with Care

- ☐ My child has been to the dentist before.
- ☐ My child has had a negative experience at the dentist.
- ☐ My child likes going to the pediatrician.
- ☐ My child is sensitive to noise and sounds.
- ☐ My child is shy.
- ☐ My child has trouble listening and following directions.
- ☐ My child can watch television (at the dentist).
- ☐ My child does NOT like dogs.

☐ Other concerns I would like to talk about (please specify):

_____

_____

_____

_____

_____

_____

_____

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Risk Assessment Form for Infant Oral Health

Health History

Did birthmother have problems during pregnancy?_____

Was the child premature?_____

Was child's birthweight low?_____

Were there any complications at birth?_____

Has your infant been ill?_____

Is your child on any medication?_____

Notes:_____

Diet and Nutrition

Is/was your child breastfed? _____

Does your child sleep with a bottle?_____

Does your child drink from a cup?_____

Is your child on a special diet?_____

Notes: _____

Fluoride Adequacy

Do you know the fluoride level of your water?_____

Do you have well water?_____

If yes, has the water been tested?_____

Do you use bottled water?_____

Do you use a water conditioner or filtration system?_____

Does your child take fluoride supplements?_____

If yes, please list:_____

Do you use a fluoridated toothpaste for your child?_____

Notes:_____

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Oral Habits

Does your child use a pacifier?_____

Does your child suck a thumb or finger(s)?_____

Does your child grind teeth day or night?_____

Notes:_____

Injury Prevention/Trauma

Is your child walking?_____

Is your home childproofed?_____

Do you used a car seat for your child?_____

Has your child had an oral/facial injury?_____

Notes:_____

Oral Development

Does your child have any teeth?_____

Child's age (in months) when first tooth erupted:_____

Has your child experienced teething problems?_____

Have you noticed an oral problems in your child?_____

Notes:_____

Oral Hygiene

Do you clean your child's teeth/gums?_____

Do you use a toothbrush to clean your child's teeth?_____

Do you use toothpaste to clean your child's teeth?_____

Notes:_____

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Child Sleep Questionnaire

Child's Age: _____

Parents:

Have you ever been tested or diagnosed with a sleep disorder? If so, what?

_____

Do you have a dental home, and do you see your dentist at regularly scheduled intervals?

_____

Check all that apply:

- ☐ Your child snores loudly, or on a regular basis
- ☐ Has pauses, gasps or snorts and actually stops breathing when asleep
- ☐ Wets the bed (answer for children over age 4)
- ☐ Is restless or sleeps in abnormal positions with his/her head in unusual positions
- ☐ Is hyperactive or shows behavioral or social problems in school
- ☐ Is difficult to wake up
- ☐ Had headaches during the day and more in the morning
- ☐ Is often irritable, aggressive, or cranky
- ☐ Is very sleep during the day (for children over the age of 2)
- ☐ Speaks with a nasal voice and breathes regularly through the mouth

Doctor's Notes:

Short jaw:

Large tongue:

Big tonsils:

Small short nose:

Nasal voice:

Chronic mouth breather:

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Pediatric Questionnaire

1. Does your child have trouble going to bed or falling asleep? ☐ Yes ☐ No
2. Awaken during the night and have trouble returning to sleep? ☐ Yes ☐ No
3. Does he/she tend to breathe through their mouth during the day or during sleep? ☐ Yes ☐ No
4. Have dry mouth or bad breath upon waking in the morning? ☐ Yes ☐ No
5. Have you notices any of the following while your child is sleeping?
   - ☐ Snoring, heavy or loud breathing
   - ☐ Break or pause in breathing
   - ☐ Gasp, choke, or struggle to breathe
   - ☐ Restless or agitated sleep
   - ☐ Grinding teeth
   - ☐ Abnormal head posture (hyper-extension, etc.)
   - ☐ Excessive sweating
   - ☐ Wetting the bed

Have you noticed any of the following during the day?

6. ☐ Difficulty waking
   ☐ Groggy, tired or "out of it"
   ☐ Hyperactive
   ☐ Teachers commented on behavior
   ☐ Wakes with headaches
7. Child often:
   - ☐ Does not seem to listen when spoken to directly
   - ☐ Has difficulty organizing tasks
   - ☐ Easily distracted by extraneous stimuli
   - ☐ Fidgets with hands or feet or squirms in seat
   - ☐ Interrupts or intrudes on others
8. Is your child frequently sick, have a history of sore throat, ear infections, sinus infections, or allergies? _____
9. Stop growing at a normal rate at any time since birth? Overweight? _____
10. Habits such as: pacifier/ thumb sucking/ lip biting/ other? _____

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Medical Information Release Form

HIPAA Release Form

Name: _____ Date of Birth: _____

Release of Information

☐ I authorize the release of information including the diagnosis, treatment records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse/Phone Number: _____
- ☐ Child(ren): _____
- ☐ Other/Phone Number: _____
- ☐ Information is not to be released to anyone

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages sent by Richards Frankel Dentistry

Please call: ☐ Home ☐ Work ☐ Cell

Preferred Number: _____

Signed: _____ Date: _____

Witness: _____ Date: _____

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Cancellation Policy

RESTORATION AND HYGIENE APPOINTMENTS

We ask for at least 48 hours advance notice for canceling or rescheduling an appointment; otherwise, a $50 fee may be assessed to your account.

Note: all cancellation fees must be paid prior to scheduling another appointment.

The treatment that is planned for you is specific to you. It is important for you to keep the scheduled dates and the times to properly complete your treatment. A broken appointment is a loss to three people— the patient who missed the valuable time, the patient who could've taken the valuable time; and the doctor who was fully staffed and prepared for the appointment.

Signature: _____ Date: _____

ACKNOWLEDGEMENT AND RELEASE

Insurance

We Provide services for patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, however the dentist treatment recommendations or fees are not affected by the presence or absence of insurance benefits. Treatment recommendations are based on your dental needs and desires and are not a reflection of your dental benefits. Your dental benefits are a contract between you, your employer and the insurance company, therefore we do not confirm insurance eligibility or predetermined recommended treatment. We are not preferred providers or members or have any association with any insurance organizations.

Collections

In the event the balance becomes more than 120 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

Signature: _____ Date: _____