24 Commerce St.,11th Floor
Newark, NJ 07102
Tel: 973-639-1000
Fax: 973-639-1006
info@dentalkidz.com
www.dentalkidz.com

PATIENT REGISTRATION INFORMATION

Name of School: ____________________

Patient's (Child's) Name: ____________________

Date of Birth: __________ Sex: M F (Circle One) SSN: __________

Who referred you to our office? : ____________________

Parent/Guardian Information

Name of Responsible Party: __________ Relationship to Child: __________

Date of Birth: __________ Sex: M F (Circle One) SSN: __________

Mailing Address: ____________________

City, State, Zip Code: ____________________

Home Phone: __________ Work Phone: __________ Cell Phone: __________

E-Mail: ____________________

Dental Insurance Information

Name of Insured Party: __________ Relationship to Child: __________

Date of Birth: __________ Sex: M F (Circle One) SSN: __________

Employer Name: ____________________

Employer Address: ____________________

Name of Dental Insurance Company: ____________________

Insurance ID #:: __________ Insurance Group #: __________

To the best of my knowledge, the questions on this form have been accurately answered. I give my permission for Dr. Levene Harvell and staff supervised by Dr. Levene Harvell to perform exams, x-rays/photos, cleaning, fluoride, sealants, behavior management techniques, and any/all treatment deemed necessary for the above named child. I have read and understand this consent form. I have been given an opportunity to ask questions about the treatment. I understand that I have the right to be provided with answers to the questions that I might have during the course of my child's treatment. I understand that I am free to withdraw my consent to treatment at any time. I assign directly to Dr. Levene Harvell all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not covered by insurance. I hereby authorize the doctor to release all information necessary including the diagnosis and records of any examination or treatment provided to my child to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Parent or Guardian: ____________________ Date: __________

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CHILD'S MEDICAL HISTORY

Name of Pediatrician: ______________________________ Telephone: ______________________

	Yes	No
Is your child under the care of a doctor now?	______	______
Since when and why?: ______________________________		
Does your child take any medications, vitamins or fluoride tablets?:	______	______
Please list: ______________________________		
Is your child allergic to anything? Medications, latex, food, other?:	______	______
Please list: ______________________________		
Has your child ever been hospitalized?	______	______

When?: ______________________ Why?: ______________________________

DOES YOUR CHILD HAVE OR HAVE THEY EVER HAD ANY OF THE FOLLOWING? IF YES PLEASE CHECK

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Behavioral Problems
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Convulsions
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eyesight Problems
- ☐ Fainting
- ☐ Hearing Problems
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Learning Problems
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Persistent Cough
- ☐ Prolonged Bleeding
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Seasonal Allergies
- ☐ Other

____
____
____
____

The information I have given is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. I understand that it is my responsibility to inform Dental Kidz of any changes in medical status.

Signature of Parent or Guardian: ______________________________ Date: ____________________

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ACKNOWLEDGEMENT OF TREATMENT ROOM POLICY

At Dental Kidz, for examinations the parent is invited into the examination. However, for follow up treatment we ask that parents remain in the waiting area. Do not be alarmed if your child cries or exhibits some form of separation anxiety as these are normal responses for a child.

The doctor and staff are well trained in calming apprehensive children. We find that parents in the treatment room are distracting for the child, doctor and staff. Many children behave differently when they know their parent is watching and may feel if they act out enough their parent will "rescue" them. Additionally the parent's anxiety increases the anxiety of the child. We want to make the visit as comfortable as possible for your child. For these reasons we ask that you respect this policy.

I understand that I WILL NOT, for any reason, be able to come into the treatment room with my child. I also understand that I WILL NOT be able to walk my child back to the treatment room.

______________________________	______________________
Child's Printed Name	Date of Birth
______________________________	______________________
Parent/Guardian Printed Name	Relationship to Patient
______________________________	______________________
Signature	Date

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AUTHORIZATION OF PERSONS TO CONSENT FOR TREATMENT

[If you want other persons to be able to consent for the treatment of the patient, this authorization is required by state law]

PLEASE READ THE FOLLOWING STATEMENT CAREFULLY:

Patient Name: ____

Patient Date of Birth: ________________________________

By signing this form, you authorize the following individual(s) to accompany for treatment and consent for treatment of above-listed patient. (PLEASE NOTE: Unless step-parents, grandparents, aunts, uncles, neighbors or others are named legally as guardian of the patient, you should include their names here if you would like for them to have access to the patient's chart).

Individual's Name: ________________________________ Relationship to patient: __________________
Individual's Address: ________________________________ Phone Number: __________________________
____

Individual's Name: ________________________________ Relationship to patient: __________________
Individual's Address: ________________________________ Phone Number: __________________________
____

Individual's Name: ________________________________ Relationship to patient: __________________
Individual's Address: ________________________________ Phone Number: __________________________
____

Individual's Name: ________________________________ Relationship to patient: __________________
Individual's Address: ________________________________ Phone Number: __________________________
____

Signature of Individual Authorizing Other Individual's Right to Consent for Patient:

____
Parent/Guardian Signature

____
Relationship to Patient

____
Date

* * * NOTE: If there is a custody agreement, this individual must be the person who has healthcare decision-making rights for the child.

FOR OFFICE USE ONLY:

Witness Name (printed): ____________________________ Witness Signature: ______________________________

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, ________________________________, understand that a copy of this office's Notice of Privacy Practices can be given to me upon request.

Patient Name: ____________________________________

Parent/Guardian Name: ____________________________

Relationship to patient: ____________________________

Signature: __________________________________ Date: ________________________

____

For Office Use Only – DO NOT SIGN BELOW

____

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

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- Emergency situation prevented us from obtaining acknowledgment

Other (Please Specify): ____

____

____

Name (Please Print) ___________________________________

Signature __________________________________ Date ______________________________