Patient Registration

First Name: _____ Last Name: _____ Middle Initial: ___

Preferred Name: _____ DOB: _____ Sex: □ Male □Female

Address: _____ City, State, Zip: _____

Home#: _____ Cell#: _____ Soc. Sec. #: _____

Referred By: _____ Previous Dentist: _____

Responsible Party

First Name: _____ Last Name: _____ Middle Initial: ___

Address: _____ City, State, Zip: _____

Home#: _____ Work#: _____ Ext: _____ Cell#: _____

DOB: _____Driver's License#: _____ Relationship to patient: _____

E-mail: _____ Preferred Language: _____

□ I would like to receive correspondence via e-mail

□ Responsible Party is Policy Holder for the Patient□ Primary Insurance Policy Holder □ Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____ Soc. Sec. #: _____

Insured DOB: _____ Relationship to Insured: _____ Phone #: _____

Employer: _____ Phone#: _____

Address: _____ City, State, Zip: _____

Ins. Company: _____ Member ID #: _____

Group #: _____ Phone#: _____ Address: _____

City, State, Zip: _____

Patient's Physician: _____ Phone#: _____

Physician's Address: _____

Is your child under the care of a physician for any illness or health problem? □**Yes** □**No**

1. Does your child have or ever had any of the following health conditions?

Abnormal Bleeding Problems	□Yes	□No	**Fainting**	□Yes	□No
Aids or Aids Related Complex	□Yes	□No	**Hearing Problems**	□Yes	□No
Allergies	□Yes	□No	**Heart Murmur**	□Yes	□No
Anemia	□Yes	□No	**Heart Problems**	□Yes	□No
Asthma or Other Respiratory Problems	□Yes	□No	**Hepatitis, Jaundice or Liver Problems**	□Yes	□No
Arthritis	□Yes	□No	**High Blood Pressure**	□Yes	□No
Artificial Limb or Implant	□Yes	□No	**Hyperactivity**	□Yes	□No
Bladder Disorder	□Yes	□No	**Kidney Disorders**	□Yes	□No
Blood Disorder	□Yes	□No	**Learning Disability**	□Yes	□No
Blood Transfusion	□Yes	□No	**Developmental Delay**	□Yes	□No
Cancer	□Yes	□No	**Premature Delivery**	□Yes	□No
Cerebral Palsy	□Yes	□No	**Pregnancy**	□Yes	□No
Convulsions or Seizures	□Yes	□No	**Radiation Therapy**	□Yes	□No
Diabetes	□Yes	□No	**Rheumatic Fever or Heart Disease**	□Yes	□No
Ear, Nose or Throat Problems	□Yes	□No	**Tuberculosis**	□Yes	□No
Emotional Problems	□Yes	□No	**Hyper or Hypo Thyroidism**	□Yes	□No

Please explain "YES" answers above: _____

2. Does your child have any disease, syndrome or handicap not listed above? _____
3. Is your child taking any over the counter drugs or prescription medications? □Yes □No
   If yes, please describe: _____
4. Has your child had any allergies or any adverse side effects to any drugs or medications, including local anesthetic, penicillin, codeine, fluoride, etc.? ___ **IF "YES" EXPLAIN**:_____
5. Has your child ever been hospitalized? ____ **IF "YES" EXPLAIN**: _____
6. Has your child ever had any surgeries? ____ **IF "YES" EXPLAIN**:_____
7. Has your child or any relative had problem with general anesthesia? _____ **IF "YES" EXPLAIN: _____**
8. Does your child have any allergies (non-drug related)? _____ **IF "YES" EXPLAIN: _____**

Dental Information

1. Is this your child's first visit to the dentist? □Yes □No
2. Has your child complained about dental problems? □Yes □No
3. When was your child's last trip to the dentist? _____
4. Has your child had an unhappy dental experience? □Yes □No
5. Who brushes your child's teeth? _____ How often? _____
6. Do you drink well water, city water, or bottled water? _____
7. Is your child going to sleep with a bottle? □Yes □No
8. What does the bottle contain □Water □Milk □Formula □Juice □Other _____
9. Is your child presently breast-feeding? □Yes □No
10. Any oral habits (thumb sucking, pacifiers, nail biting, etc.)? _____
11. Any history of injuries to mouth, teeth, or head? □Yes □No

Please explain "YES" answers above: _____

The statements on both sides of this form are, to the best of my knowledge true and correct. I agree to report any health changes to the Doctor prior to treatment. I hereby authorize the Doctor and staff to provide examination, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

_____ _____ _____

Patient's Name Signature of Parent or Legal Guardian Date

Financial Agreement

I, the undersigned, hereby agree to pay STUART PEDIATRIC DENTISTRY fees for services rendered. I further agree that payment is due when such services are rendered unless prior arrangements are made. I understand that unpaid accounts will be considered delinquent after thirty (30) days and in default after forty-five (45) days, after which time interest will be at a rate of 1 ½% per month on unpaid balances (annual percentage rate of 18% or the legal interest rate, whichever is lower). In the event a legal suit or collections are necessary to enforce payment of this account, I agree to pay such attorney fees, court costs or collection fees, as are deemed reasonable. I waive venue jurisdiction and submit myself to the jurisdiction and venue of the Courts of Martin County, State of Florida.

Assignment of Insurance Benefits

I hereby authorize payment to be made directly to STUART PEDIATRIC DENTISTRY, or other agent of their choosing, for benefits that may be due and payable under insurance coverage for my co-insured and me. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments. I further acknowledge that this assignment of benefits does not in any way relieve me of liability and that I remain financially responsible to STUART PEDIATRIC DENTISTRY for any fees unpaid by my insurance company or dental plan.

For Patients with Health Exchange Plans

Patients who have health insurance through the Marketplace will need to sign a credit card authorization form to be kept on file here in our office. The Marketplace can indicate you have coverage at the time of service and even pay your claim, only to find that your coverage has previously lapse due to your late payment or nonpayment. They then demand an immediate refund from the practice, long after your care has been given. If this were to happen we would call you to notify you and have the ability to then bill your card.

_____ _____

Parent or Guardian Name Signature

Attendance Policy

I agree to keep my scheduled appointments. I agree that unless my scheduled appointment is **cancelled at least 48 hours in advance**, I will be liable to pay a **broken appointment fee of $50**. Furthermore, we reserve the right to not re-schedule appointments for those patients that have 2 failed appointments or last minute cancellations.

I agree to arrive at least 10 minutes before the appointment time to allow processing; also I am aware that if I arrive 10 minutes after the scheduled appointment time, I will be considered to be late and that I might not be able to be seen. The office will try to move the appointment to a later time that is available, but it is not a guarantee, in some occasions depending on the type of appointment and the availability of the schedule we might have to reschedule to another day.

Stuart Pediatric Dentistry strives to provide each patient with the highest quality of care while accommodating your schedule. We reserve time allotments for each patient; therefore, keeping your appointments on a consistent basis is a key factor for establishing your dental home.

_____ _____ _____

Parent or Guardian Name | Signature | Date

Pediatric Dentistry General Consent for Dental Procedures and

Acknowledgement of Receipt of Information

I hereby authorize and direct **Dr. LUIS A. MATOS** and staff to perform upon my child _____ all necessary dental services he/she may need; including one or more procedures: Radiographs of teeth and jaws, cleaning of teeth and application of fluoride, use of local anesthesia to numb teeth and tissues, treatment of injured teeth with dental restoration (fillings), removal of one or more teeth, treatment of disease or injured oral tissues (hard and/or soft), treatment of malposed (crooked) teeth and/or oral development or growth abnormalities, replacement of missing teeth with dental prosthesis.

Other: _____

I understand, through discussions with the doctor the nature and purpose of these procedures. Alternate procedure or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, the risks, consequences and probable effectiveness or each, as well as the prognosis if no treatment is provided. I understand that there is no guarantee that the dental procedures will be successful; however, the procedures are desired and intended to result in improved oral conditions.

I also authorized the doctor to use photographs, radiographs, other diagnostic material and treatment records for the purpose of teaching, research and scientific publications.

I agree that verbal discussions with the doctor has outlined why the procedures are recommended, what alternative treatments are available, what risks, consequences, and complications may result from these procedures, and that all my questions have been answered satisfactorily. I also agree that all blanks above on this consent form were filled in before I was asked to sign it.

I further understand that I am free to withdraw my consent to treatment at any time and that this consent will remain in effect until such time that I choose to terminate it.

_____	_____	_____
Patient's name	Signature of parent or Guardian	Date

_____	_____
Witness	Relationship to patient

900 SE Ocean Blvd, Suite B-118 * Stuart, FL 34994 * Telephone 772.600.5130 * Fax 772.600.5523 * www.stuartpediatricdentistry.com

STUART PEDIATRIC DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature Date