Edwin Zaghi DMD PC

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Child Registration, Health History, and Informed Consent

CHILD REGISTRATION

Today's Date: _____/_____/_____

Patient Name: _____ Birth Date: _____/_____/_____

Patient lives with: □ Both parents □ Mother □Father Other: _____

Father's Name: _____ (FIRST MIDDLE LAST)	Mother's Name: _____ (FIRST MIDDLE LAST)
Street Address: _____	Street Address: _____
Town: _____ Zip: _____	Town: _____ Zip: _____
Social Security #: _____ D.O.B.:_____	Social Security #: _____ D.O.B.:_____
Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____
Cell Phone: _____	Cell Phone: _____
Employer: _____	Employer: _____
Employer Address: _____	Employer Address: _____
_____	_____
Email: _____	Email: _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Subscriber Name: _____	Subscriber Name: _____
Insurance Co. Name: _____	Insurance Co. Name: _____
Group Plan/Employer's Name: _____	Group Plan/Employer's Name: _____
Group #: _____	Group #: _____
Insured ID #: _____	Insured ID #: _____
Ins. Co. Address: _____	Ins. Co. Address: _____
_____	_____
Ins. Co. Phone #: _____	Ins. Co. Phone #: _____

As a courtesy, we accept assignment of benefits from your insurance carrier. As we deal with insurance on your behalf, carriers require that we keep your signature on file. Please sign both statements below.

I reviewed the treatment plan(s) and I authorize the release of any information relating to the claim(s).
I hereby authorize direct payment to the above named dentists of the group insurance benefits otherwise payable to me.

_____
Signature of insured parent / guardian

For those patients without insurance coverage, payment in full is required at the time of the treatment. For patients with insurance, the co-pay and/or deductible is due at the time of treatment. The parent who accompanies the child to our office is responsible for payment at the time of service unless arrangements have been made prior to the visit. All office correspondence will be addressed to the child's place of residence. It is important that you keep our office aware of changes in your address, phone numbers, and insurance status.

By signing below you acknowledge that you understand our office policies.

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

Edwin Zaghi DMD PC
Pediatric Dentistry

Dear Parents:

Welcome to our office! We trust that you will be happy with the care provided, and hope that your child's dental experiences will be pleasant ones. In order to avoid any confusion, we have developed the following office policies.

Patients With Insurance: We will be happy to file all claims as a courtesy. If necessary, we will send a pre-determination of benefits to your insurance company. This will state how much the insurance will cover and how much will be due by you. Please note, some routine dental services are not covered in full by all insurance carriers. Payment of insurance balances will be due at each appointment. We accept MasterCard, VISA, and Discover.

Patients Without Insurance: We will be happy to provide you with a written estimate of costs if you have no insurance. All fees are due at the time of service. We accept MasterCard, VISA, and Discover.

Minor Patients: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent who brings the child for treatment shall have full responsibility to pay all charges. This office will not become involved in reimbursement requests and will not separate or split bills.

Returned Checks: There will be a $30.00 charge for returned checks.

Duplication of X-Rays: Original x-rays and records are the property of this office and *always* remain in this office. Maryland law allows 21 (twenty-one) days for an office to provide the duplicates.

Emergency Coverage: There is 24 hour emergency coverage. A call to (410)992-4400 will connect you to an answering machine and a recorded message will direct you how to contact Dr. Zaghi or one of his associates.

Please feel free to approach any of us anytime you have a question about your child's care or about any charges that have been incurred. We truly value your trust and confidence and will try to provide you with the finest professional care available.

Professional appointment times are very valuable. Our office tries to accommodate the busy schedules of our patient's parents. Therefore, we ask that you be considerate of other parents and our staff by informing this office, at least 48 hours in advance, if you will be unable to keep your appointment(s). There may be a $50.00 canceled appointment charge *per child* if appropriate notice is not given. This office reserves the right to terminate professional treatment of any patient who continually fails to keep scheduled appointments.

Signature of Parent/Guardian_____Date_____

Edwin Zaghi DMD PC
CHILD'S HEALTH HISTORY

Today's Date: ____/____/_____

MEDICAL HISTORY

Child's Name: _____ Birth Date: ____/____/_____
First Middle Last
Gender: □ Male □ Female Nickname: _____

Child's Pediatrician& phone number: _____ _____-_____-_____
Date of last medical exam: ____/____/_____

- Is your child:
  In good health? □ Yes □ No Taking medication(s): □ Yes □ No
  Under active medical care? □ Yes □ No Medicine(s): _____
  Explain: _____ Dose(s): _____

- Does your child have any allergies? □ Yes □ No
  If yes, please describe: (i.e. food, drug, latex, etc.) _____

- Has your child been hospitalized or required surgery? □ Yes □ No If Yes, describe below:
  Date(s): _____
  Reason(s): _____

- Has your child ever had a blood transfusion? □ Yes □ No
  If Yes, please explain: _____

- Has your child had any history of illness or difficulty with the following? (Circle all that apply and explain below)

ADHD	ANEMIA	ARC	ASTHMA	AUTISM
BLEEDING DISORDER	CANCER	CEREBRAL PALSY	CLEFT LIP	CLEFT PALATE
DEVELOPMENTAL DELAY	DIABETES	DRUG REACTION	EMOTIONAL DISABILITY	ENDOCRINE SYSTEM
HEART DEFECT, DISEASE OR MURMUR	HEARING IMPAIRMENT	HEADACHES	HEPATITIS	HIV+OR AIDS KIDNEY
LEARNING DISABILITY	LIVER	LUNG DISEASE	RHEUMATIC FEVER	SIEZURES/EPILEPSY
SPEECH DISORDER	THYROID	TUBERCULOSIS	TUMOR	VISION IMPAIRMENT

Please explain each item circled above:

_____

_____

_____

_____

DENTAL HEALTH HISTORY

- How do you expect your child to react to the visit today? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

Explain: _____

- When does your child brush (check all that apply)? ☐ A.M. ☐ P.M. ☐ After snacking / eating
  - Does an adult assist with brushing? ☐ Yes ☐ No When? _____
  - Do you or your child use dental floss in cleaning his/her teeth? ☐ Yes ☐ No

- Does your child receive fluoride in any of the following forms?
  - Fluoride tablets or fluoride multivitamins: ☐ Yes ☐ No Dosage: _____ mg/day
  - Water supply (either well or town water): ☐ Yes ☐ No ☐ Don't Know
  - Toothpaste: ☐ Yes ☐ No - Rinse/Gel: ☐ Yes ☐ No - Professional topical application: ☐ Yes ☐ No

- Please let us know if your child has any oral habits:
  ☐Bottle/sippy cup usage ☐Thumb / Finger sucking ☐Pacifier ☐ Mouth breathing ☐Teeth grinding ☐Lip sucking

- Has your child had any injuries to the teeth, mouth, or jaws? ☐ Yes ☐ No
  Explain (age, teeth involved, nature of accident, treatment rendered): _____
  _____

- Present dental problem (if any): _____

- Is this your child's first visit to the dentist? ☐ Yes ☐ No
  If No: Name of prior dentist: _____ Date of visit: ____/____/_____
  Purpose of last visit: _____

- Has your child ever had dental x-rays? ☐ Yes ☐ No If yes, Date: ____/____/_____

- Has your child had unpleasant dental experiences? ☐ Yes ☐ No
  Explain: _____

- How may we make this visit a positive experience for your child? _____
  _____

- Have any other children in your family been to our office? ☐ Yes ☐ No
  Names and ages of other children: _____

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

I certify that the above information is complete and accurate, to the best of my knowledge. In addition, I will inform the office of any changes in my child's medical status.

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

Thank you for filling out this form completely; your cooperation will enable us to help your child more effectively. If you have any questions, please ask us.
We appreciate your confidence in choosing our office and we look forward to an ongoing relationship with you.

Edwin Zaghi DMD PC
CONSENT FOR TREATMENT

I hereby request and authorize Dr. Zaghi and his staff to perform any necessary dental treatments on my child, _____. I have been fully informed of the details of the recommended treatment and alternatives, and agree to accept the treatment.

I understand that as treatment proceeds, there may be the need to change the treatment plan. If this occurs, I will be consulted prior to the initiation of such procedures. I further acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I understand that individual reactions during or following treatment cannot be predicted and if my child experiences any unanticipated reactions during or following treatment, I agree to report them to the office as soon as possible.

I have been told that the success of the recommended treatment depends upon my cooperation in keeping the scheduled appointments, following home care instructions, including oral hygiene and dietary instruction, and reporting to the office any changes in my child's health status as soon as possible.

I understand that there may be side effects from dental treatment that may include, but not limited to the following: infection, pain, swelling, laceration of oral tissues, aspiration or swallowing of objects, and emotional upset.

I understand that the administration of certain drugs may be necessary, including, but not limited to, local anesthetics, antibiotics, and pain medications. I am aware that there is a slight element of risk inherent in the administration of any drug and that this risk includes, but is not limited to, an adverse drug reaction.

I understand that some children are not cooperative enough to tolerate treatment in the dental office and may require sedation or treatment in the operating room under general anesthesia.

For those patients having nitrous-oxide—I understand that nitrous-oxide (Laughing Gas) is going to be used with my child. I have been informed that my child will be fully awake, able to speak, understand, and answer questions. Further, I have been informed that it is used to make my child more comfortable and to allay any fears that he/she may have. I understand that my child should not eat or drink for five hours prior to the appointment when nitrous-oxide is being used. The doctor has told me that the complications, if they occur, can include nausea, vomiting, and drowsiness. I consent to allow the use of nitrous-oxide.

I have discussed all of the above with the doctor, and all of my questions have been answered. I hereby authorize the treatment to be completed and agree to pay the charges I incur.

_____	_____	_____/_____/_____
Signature of Parent/Guardian	Relationship	Date

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NOTICE OF PRIVACY PRACTICES
PARENT/GUARDIAN DISCLOSURE FORM

This form is required by the Health Insurance Portability and Accountability Act of 1996 in compliance with the privacy regulation effective for this office on April 14, 2003, only if our office wishes to use or disclose your protected health information for any other purpose not clearly spelled out in our office Privacy Policy Notice.

To use or disclose your protected health information in such cases, our office must receive prior written authorization from you. Our office will condition treatment, payment, enrollment or eligibility for benefits on whether you sign this authorization.

The purpose for which our office is requesting your authorization is to diagnose and complete treatment. The information to be disclosed would include your protected health information (PHI). The information may be disclosed to, but not limited to, laboratories, hospitals, insurance companies, medial and dental referrals, and other health care professionals. This form also authorizes the use of photography as a diagnostic tool.

By agreeing to this authorization, you understand that the potential for information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by the privacy regulation of HIPAA. You also understand that you are entitled to receive a copy of this authorization form.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received and viewed of this office's Notice of Privacy Practices.
Parent / Guardian Name

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of the protected health information, (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner: (check all that apply)

□ Home Telephone_____ □ Work Telephone_____

□ leave message with detailed information □ leave message with detailed information

□ leave message with call-back number only □ leave message with call-back number only

□ Written Communication □ Other_____

□ okay to send to my home address

□ okay to fax to this number _____ □ okay to e-mail to this address _____

Patient's Name:_____

Patient's or Parent's/Guardian's Signature:_____Date:_____