



# Newtown Dentistry for Kids Patient Registration

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Male/Female  
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### PARENT INFORMATION

**Mother's Name:** \_\_\_\_\_  Married  Divorced  Single  Other  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Email address: \_\_\_\_\_  
 Mother's Employer: \_\_\_\_\_ SS# \_\_\_\_\_ Work #: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_  Married  Divorced  Single  Other  
 Address(if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Email address: \_\_\_\_\_  
 Father's Employer \_\_\_\_\_ SS# \_\_\_\_\_ Work#: \_\_\_\_\_

### PRIMARY DENTAL INSURANCE

Policy Owner's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 ID #/Social Security #: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_  
 Dental Insurance Plan Name: \_\_\_\_\_  
 Claims Address: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Insurance Co. Phone#: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_

### SECONDARY DENTAL INSURANCE

Policy Owner's Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 ID #/Social Security #: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Dental Insurance Plan Name: \_\_\_\_\_  
 Claims Address: \_\_\_\_\_  
 Insurance Co. Phone#: \_\_\_\_\_  
 Relationship to patient: \_\_\_\_\_

### REFERRAL & PHARMACY INFORMATION

Whom may we thank for referring you to our office?  
 Referring Doctor/Office (Name): \_\_\_\_\_ Current Patient (Name): \_\_\_\_\_  
 Family Member (Name): \_\_\_\_\_  
 Drive By  Google  Website  Facebook  Newtown Athletic Club  Twitter   
 Health Fair  Facebook  St. Andrew's  Courier Times Website  Other   
 Pharmacy name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Emergency contact (not living with you) : \_\_\_\_\_ Phone #: \_\_\_\_\_

### CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that she/he is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 90 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination. All fees associated with collections and/or Attorneys cost will be your responsibility. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's needs. I grant permission to you or your assignee to telephone me at home and leave a message. I give my authorization to transfer any records or radiographs to another provider for treatment of my child. I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

**I have read the above conditions of treatment and payment and agree to their content.**

Signature: \_\_\_\_\_ Relationship to child: \_\_\_\_\_ Date: \_\_\_\_\_

## Newtown Dentistry for Kids New Patient Medical/Dental History Form

Patient Name: \_\_\_\_\_  

Last
First
Initial
Nickname
Date of Birth

Parent/Guardian Name: \_\_\_\_\_

**DENTAL HISTORY:**

Previous Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Date of last dental care: \_\_\_\_\_ Date of last x-rays: \_\_\_\_\_

When does your child brush his/her teeth?  Upon arising  After eating any food  After meals  Before going to bed

How does your child receive Fluoride?  Community water  Drops/tablets  Well water  Rinse/gel

Does your child eat between meals?  Y  N Has anyone in the family, including parents, had orthodontics?  Y  N

Does your child eat sweets (candy, soda pop, chewing gum)?  Y  N Has your child ever received local anesthetic?  Y  N

Has your child had cavities?  Y  N Has your child ever had occlusal sealants?  Y  N

Were any teeth (baby or permanent) removed by extraction?  Y  N Has your child had any previous problems with dental treatment?  Y  N

Was it suggested that the space be maintained?  Y  N If yes, explain \_\_\_\_\_

Was an appliance placed?  Y  N

Have there been any injuries to the teeth (falls, chips, blows)?  Y  N

If yes, explain \_\_\_\_\_

Does your **child** think there is anything wrong with his/her teeth?  Y  N

If yes, explain \_\_\_\_\_

**MEDICAL HISTORY:**

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Is your child currently under physician care?  Y  N If yes, explain \_\_\_\_\_

Has your child had any serious illnesses?  Y  N If yes, explain \_\_\_\_\_ Date \_\_\_\_\_

Has your child ever had surgery?  Y  N If yes, explain \_\_\_\_\_ Date \_\_\_\_\_

Has your child ever been hospitalized?  Y  N If yes, explain \_\_\_\_\_ Date \_\_\_\_\_

Please list any **MEDICATION** your child is currently taking.

Please list any **ALLERGIES** your child has.

\_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_

**Have you had a history of any of the following?**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Acid reflux disease (GERD)      | <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Liver problems                |
| <input type="checkbox"/> ADD/ADHD                        | <input type="checkbox"/> Eyesight problems           | <input type="checkbox"/> MRSA                          |
| <input type="checkbox"/> Anemia                          | <input type="checkbox"/> Fainting Spells             | <input type="checkbox"/> Psychiatric disorders         |
| <input type="checkbox"/> Arthritis, Rheumatism           | <input type="checkbox"/> Frequent headaches          | <input type="checkbox"/> Organ Transplants             |
| <input type="checkbox"/> Artificial Heart Valves         | <input type="checkbox"/> Hayfever                    | <input type="checkbox"/> Prosthetic Replacement        |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Hearing loss                | <input type="checkbox"/> Radiation Therapy             |
| <input type="checkbox"/> Autoimmune Disease              | <input type="checkbox"/> Heart murmur                | <input type="checkbox"/> Rheumatic Fever               |
| <input type="checkbox"/> Autism                          | <input type="checkbox"/> Heart trouble               | <input type="checkbox"/> Seizures                      |
| <input type="checkbox"/> Cancer                          | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Sexually Transmitted Diseases |
| <input type="checkbox"/> Cardiac Transplant              | <input type="checkbox"/> Hemophilia                  | <input type="checkbox"/> Severe/ prolonged bleeding    |
| <input type="checkbox"/> Chemical/Alcohol Dependency     | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Speech impairment             |
| <input type="checkbox"/> Congenital heart defects        | <input type="checkbox"/> Herpetic Lesions/Cold Sores | <input type="checkbox"/> Thyroid Disease               |
| <input type="checkbox"/> Diabetes If yes what age? _____ | <input type="checkbox"/> HIV/AIDS                    | <input type="checkbox"/> Tuberculosis                  |
| <input type="checkbox"/> Dizziness                       | <input type="checkbox"/> Immunosuppression           | <input type="checkbox"/> Other _____                   |
| <input type="checkbox"/> Eating Disorder                 | <input type="checkbox"/> Kidney trouble (dialysis)   |  |

Additional comments: \_\_\_\_\_

***I certify that the above information is complete and accurate.***

\_\_\_\_\_  
 Date                      Patient Signature                      Date                      Dentist Signature

# Newtown Dentistry for Kids

## CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct Christine M. Landes, D.M.D. and or dental auxiliaries of his/her choice to perform the following dental treatment or oral surgery procedures(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

- A. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride.
- B. Application of protective “sealants” to the grooves of the teeth.
- C. Treatment of diseased or injured teeth with dental restorations (fillings and crowns).
- D. Removal (extraction) of one or more teeth.
- E. Treatment of diseased or injured oral tissues (hard and/or soft).
- F. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.

2. I understand that there are risks involved with certain treatments and hereby acknowledge that these risks/s will be explained to me, that I will have an opportunity to ask questions regarding the treatment and the risks, and that I fully understand the same.

3. Mouth props: A mouth prop or “tooth pillow” as we call it is used to help support your child in keeping his/her mouth open for an operative procedure. This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure.

4. Immobilization by the doctor: The doctor controls the child from movement by gently holding down the child’s hands or upper body, stabilizing the child’s head between the dentist’s arm and body. This is only done when safety for the child is of concern.

5. Immobilization by the assistant: The assistant controls the child from movement by gently holding the child’s hands, stabilizing the head, and/or controlling leg movements. This is only done when safety for the child is of concern.

6. I agree to the use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor/s. Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.

7. I recognize that during the course of treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I therefore authorize and request the performance of any additional procedures that are deemed necessary or desirable to oral health and well being in the professional judgment of the dentist.

8. There are possible risks and complications associated with the administration of local anesthesia, sedation and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or near the injection site) fainting, lip and cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.

9. I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purposes of teaching, research and scientific publications, and case presentations.

10. I will be advised that the success of the dental treatment to be provided will require that the patient and the parents follow post-operative and post-care instructions of the dentist/s. I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his/her auxiliaries must be maintained.

11. I hereby state that I have read and understand this consent and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.

12. I further understand that this consent will remain in effect as long as my child is a patient at Newtown Dentistry for kids and **no treatment will be performed prior to authorization from parent or caregiver.**

Date: \_\_\_\_\_

Patient’s name: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_



**HIPAA OMNIBUS RULE  
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES  
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

**Christine Landes, DMD  
Newtown Dentistry for Kids  
46 Blacksmith Road Suite Tooth  
Newtown, PA 18940**

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: \_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

\_\_\_\_\_  
Please **print** patient name

\_\_\_\_\_  
Please **sign**

\_\_\_\_\_  
Description of Authority

Your comments regarding Acknowledgements or Consents: \_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only    Proper Sir Name    Other \_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- |  |   |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> <b>Any of the Above</b>            |
| <input type="checkbox"/> Text Message  | <input type="checkbox"/> <b>None of the above</b> (opt out) |
| <input type="checkbox"/> Email         |   |

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

**Office Use Only**

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- |  |       |
|--|-------|
| It was emergency treatment               | _____ |
| I could not communicate with the patient | _____ |
| The patient refused to sign              | _____ |
| The patient was unable to sign because   | _____ |
| Other (please describe)                  | _____ |

\_\_\_\_\_  
Signature of Privacy Officer

