Nakamura Children's Dentistry
Building Healthy Smiles

Patient Registration Form

Today's date:					
PATIENT INFORMATION					
Patient's first name: Last: Middle:			Birth date: / /	Age:	Sex: ☐ M ☐ F
Address:					
City:	State:	Zip code:	Home phone: ( )	Cell phone: Mother ( ) Father ( )	
Cell phone accepts text messages and ok to send: ☐ Y ☐ N			Guardian email address:		
Full name of Parent/Legal Guardian(s): 1. 2.					
Name and address of person who is responsible for the bills (if different from parent/legal guardian above):					
Referred by:					
INSURANCE INFORMATION (Please give your insurance card to the receptionist)					
Employer (for responsible party):			Employer address:		
City:	State:	Zip code	Work phone:	Extension	
Primary insurance:					
Insurance address:				Insurance phone:	
Subscriber's name:	Birth date: / /	Group #:	Subscriber ID # (please write all numbers):		
Name of secondary insurance (if applicable:					
Insurance address:				Insurance phone:	
Subscriber's name:	Birth date: / /	Group #:	Subscriber ID # (please write all numbers):		
Please bring your insurance card to each visit & notify us promptly of any changes. Thank you!					
IN CASE OF EMERGENCY					
Name:			Relationship to patient:		
Home phone:	Work phone:		Cell phone:		
The information above is true to the best of my knowledge. All payments shall be made to our office. I understand my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents.					
_____ Parent/Guardian signature			_____ Date		

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Medical History Form

Patient name: ☐ M ☐ F		Birth date:
Primary Physician?	Phone: ( )	Date of Last Visit:
Is your child currently seeing a physician for non-routine treatment? (Explain) ☐ No	Has your child been hospitalized, had surgery or a significant injury? (Explain) ☐ No	
Allergies to medications, vaccines, food, environment (describe reaction)? ☐ None	Current medications and doses (including vitamins and over-the-counter meds): ☐ None	
Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions? ☐ None		

Has your child ever had any of the following?

Asthma, wheezing, or breathing problems	☐ Yes	☐ No	Anemia	☐ Yes	☐ No
Cystic fibrosis	☐ Yes	☐ No	Acid reflux disease (GERD), stomach ulcer, or intestinal problems	☐ Yes	☐ No
Irregular heartbeat or high blood pressure	☐ Yes	☐ No	Bladder or kidney problems	☐ Yes	☐ No
Congenital heart disease, heart murmur or rheumatic fever; Artificial heart valve	☐ Yes	☐ No	Impaired vision, hearing, or speech	☐ Yes	☐ No
Jaundice, hepatitis, or liver problems	☐ Yes	☐ No	Seizures/epilepsy or cerebral palsy	☐ Yes	☐ No
Concerns with weight, or eating disorder	☐ Yes	☐ No	Migraines, fainting, or dizziness	☐ Yes	☐ No
Rash/hives, eczema, or skin problems	☐ Yes	☐ No	Thyroid or pituitary problems	☐ Yes	☐ No
Developmental delay or learning disability	☐ Yes	☐ No	Hemophilia, sickle cell disease/trait, bruising easily, or excessive bleeding	☐ Yes	☐ No
Autism spectrum disorder	☐ Yes	☐ No	Diabetes, hyperglycemia, or hypoglycemia	☐ Yes	☐ No
ADD or ADHD	☐ Yes	☐ No	Cancer or tumor	☐ Yes	☐ No
Behavioral or psychiatric treatment	☐ Yes	☐ No	Mononucleosis, tuberculosis (TB), sexually transmitted disease (STD)	☐ Yes	☐ No

If yes or if other significant medical history issues exist for this child, please provide details:

DENTAL HISTORY FORM

What is the primary concern about your child's oral health?

Is this your child's first dental visit? ☐ Yes ☐ No Previous Dentist:

Date/Reason of Last Visit: Date of Last X-rays:

Has your child had any of the following?

Pain from the teeth or swelling of the mouth or face	☐ Yes	☐ No	Injury to the face or teeth	☐ Yes	☐ No
Thumb sucking or other oral habit	☐ Yes	☐ No	Bad dental experience	☐ Yes	☐ No
Mouth breathing, or excessive gagging	☐ Yes	☐ No	Does your water have fluoride?	☐ Yes	☐ No

How many times does your child brush? _____/day How many times does your child floss? _____/day

How do you think your child will behave for today's appointment? ☐ Well behaved ☐ Unsure ☐ Uncooperative

Parent/Guardian Signature _____ Date _____ Reviewed by _____

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Informed Consent

Our mission is to provide the highest standard dental care by focusing on your child and creating a warm welcoming environment. However, additional behavior management techniques may be necessary. These techniques are recommended by the American Academy of Pediatric Dentistry and may be used, to complete a dental procedure in a safe manner.

Tell-Show-Do: The dentist/assistant explains to your child what is to be done using age appropriate terminology and then demonstrates what is to be done. Praise is used to reinforce cooperative behavior.

Positive Reinforcements: This technique rewards the child who displays any behavior that is desirable.

Mouth Props "tooth pillow": A soft, rubber device is used to assist the child in keeping their mouth open during the procedure to prevent their jaw from getting tired. This allows the child to relax and not worry about consciously keeping their mouth open.

Protective Stabilization: The dentist/assistant gently protects the child from movement by holding the child's hands, stabilizing the child's head and/or using a papoose wrap. This is for the child's safety and only used with additional consent.

Nitrous oxide/Oxygen: Is administered to relax the child, allow the child to sit in the chair longer and allow for more work to be done. It is not general anesthesia and the child is not "put to sleep." Additional consent is obtained.

I understand dental treatment is associated with inherent risks, including, but not limited to:

1. Injury to the nerves as a result of local anesthesia: May include injuries causing numbness of lips, tongue, or other tissues of the mouth or face. This numbness is usually temporary, but if numbness persists more that 24 hours, please call our office.

2. Soreness of the gums: Temporary soreness may result from placement of a rubber dam, or any restoration that extends below the gumline (e.g. stainless steel crowns). This soreness usually goes away within 48 hours.

3. Sensitivity of teeth: Placement of any dental restoration can result in sensitivity to hot and/or cold. If these symptoms persist for more than a few weeks, it may be an indication that further treatment is necessary.

4. Breakage, dislodgement, or bond failure: Teeth are subjected to forces from chewing, grinding, and trauma. Bonded/white fillings or amalgam/silver fillings can be fractured or dislodged, resulting in leakage, recurrent decay, or infection.

*5. Dental extractions***:** Bleeding, swelling or bruising may occur. If severe or persistent, please call our office. Injury to adjacent teeth or restorations may occur no matter how carefully the surgery is performed. Infection is a possibility due to the non-sterile nature of the mouth. Some infections can be serious if severe swelling occurs, with fever or malaise, please call immediately.

*6. Endodontically treated teeth***:** In a small percentage of cases, the nerve treatment is unsuccessful, and the tooth requires an extraction. This treatment is used when short term retention of a primary tooth is important to long term dental health.

It is the parent/guardian's responsibility to seek attention should any complication occur post-operatively and I shall diligently follow any instructions given to me by the dentist.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the proposed treatment and have received answers to my satisfaction. I have been given alternatives, including the option of rendering no treatment. I understand and assume any and all risks associated with the procedures, and that no guarantees have been made. I freely give my consent to Nakamura Children's Dentistry and their staff to render treatment, including any anesthetics or medications.

_____
Patient Name / DOB

_____
Patient Name / DOB

_____
Patient Name / DOB

_____ _____ _____ _____
Patient Name / DOB | Parent/Guardian Name | Parent/Guardian Signature | Date

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Office Policies/Financial Agreement

Thank you for making an appointment with us. We appreciate the opportunity to provide dental care for your family. Because we value our relationship with you, we would like to acquaint you with our office and financial policies.

Insurance information: As a courtesy to our insured patients, we will submit claims to your insurance company on your behalf. We ask that you provide us with your insurance card and any updated insurance information.

Dental plans rarely cover all dental costs. We would appreciate if all unmet deductibles and copayments are paid at each visit, unless prior arrangements are made.

Treatment plan estimates: As a courtesy, we will provide treatment plan estimates so you have an estimate of your patient portion. However, treatment plans may change and this is only an estimate of what insurance will cover.

Payments: We accept cash, checks and credit cards. A fee is charged for all returned checks. All balances over 60 days are considered past due. We will make our best attempt to communicate with you regarding past due balances.

Responsibility of account: We realize many families are in a state of change. Divorced, separated, single parent and blended families are common. Our policy is that the parent/guardian who brings the child to the appointment is ultimately responsible for fees incurred; regardless of insurance or custody arrangements. We ask that these conversations are discussed prior to appointments, and arrangements are clear between parents and our office.

Missed/Broken Appointments: We do our best to accommodate our patients with convenient appointments. As such, we request a 24 hour cancellation notice. Cancellations made less than 24 hours, or failed appointments will be assessed a $30 charge. Unforeseen events may require missing an appointment and therefore, fees are assessed after the 2nd missed appointment. After 3 missed appointments, we will only schedule on an emergency basis.

Late Arrival: We reserve a certain amount of time for your appointment. If you are over 15 minutes late to your appointment, we may need to reschedule your appointment.

We hope you find this information helpful. Let us know if you have any questions regarding your account or our office policies. Please indicate that you have read and understand the above information by signing below.

_____
Patient Name / DOB

_____
Patient Name / DOB

_____
Patient Name / DOB

_____ _____ _____ _____
Patient Name / DOB Parent/Guardian Name Parent/Guardian Signature Date