Kshama Kheny, DDS - *Cosmetic and Family Dentistry*

Registration Form for a Minor Patient

(Age: Below 18 year)

Today's Date:_____

Patient Information			
Patient's Name (First, Last, MI):	Gender: [ ] Male [ ] Female	Date of Birth:	
E-Mail Address:	Home Phone:	Cell Phone:	
Address (not P.O. Box)	City:	State:	Zip:

School Information				
School:	Grade:	City:	State:	Zip:

Responsible Party			
Name:	Relation to patient:	Social Security #:	Driver's License # / State:
Home Phone:	Cell Phone:	Work Phone:	
Address (not P.O. Box) :	City:	State:	Zip:

Whom May We Thank For Referring You?	
[ ] Personal Referral:	[ ] Phonebook/Yellow Pages
[ ] Internet / Search Engine:	[ ] Other: _____

Emergency Contact		
Contact Name:	Phone Number:	Relationship:

Insurance Information			
Primary Insurance (provide insurance card)		**Secondary Insurance (if applicable)**	
Name of Insured (First, Last, MI):	Date of Birth:	Name of Insured (First, Last, MI):	Date of Birth:
Relationship to Patient: [ ] Parent [ ] Legal Guardian [ ] Other _____	Gender: [ ] M [ ] F	Relationship to Patient: [ ] Parent [ ] Legal Guardian [ ] Other _____	Gender: [ ] M [ ] F
Subscriber ID or SSN:		Subscriber ID or SSN:	
Insurance Company:	Group Number:	Insurance Company:	Group Number:
Insurance Phone Number:	Employee ID Number:	Insurance Phone Number:	Employee ID Number:
Insurance Mailing Address (Street Address/P.O. Box):		Insurance Mailing Address (Street Address/P.O. Box):	
City: State: Zip:		City: State: Zip:	

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Medical History *(Please circle Yes or No for each)* **Patient Name** (first, MI, last)**:**_____

1. Physician's name:_____ Physician's phone:_____

2. Date of last medical examination?_____ Weight:_____

3. Patient is in good health? Yes / No **If no, why?** _____

4. Patient has regular medical exams? Yes / No

5. Patient is under the care of a physician at this time? Yes / No **If yes, why?** _____

6. Patient is up to date with immunizations? Yes / No

7. Patient is presently taking medications? Yes / No **If yes, what and why?** _____

8. Patient has allergies (medications, food, latex/rubber)**?** Yes / No **If yes, what?** _____

9. Patient has been hospitalized? Yes / No **If yes, why and when?** _____

10. Patient has had any operations? Yes / No **If yes, why and when?** _____

11. Patient has had general anesthesia? Yes / No

12. If yes, were there any complications? Yes / No **If yes, please explain complications:**_____

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

Yes / No	Anemia	Yes / No	Heart defects
Yes / No	Arthritis, rheumatism	Yes / No	Heart disease /defects / murmurs
Yes / No	Artificial prosthesis, organs, joints, implants, shunts, valves	Yes / No	Hepatitis
Yes / No	Asthma	Yes / No	High blood pressure
Yes / No	Blood disorder	Yes / No	Jaundice
Yes / No	Blurred vision	Yes / No	Joint pain or stiffness
Yes / No	Bone pain	Yes / No	Kidney or bladder disease
Yes / No	Canker or cold sores	Yes / No	Muscle pain, weakness
Yes / No	Chest pain, tightness, wheezing	Yes / No	Persistent cough or runny nose
Yes / No	Diabetes	Yes / No	Recent significant weight loss
Yes / No	Diarrhea or constipation	Yes / No	Rheumatic fever
Yes / No	Ear infections	Yes / No	Seizures
Yes / No	Eating disorders	Yes / No	Sexual transmitted disease
Yes / No	Excessive thirst	Yes / No	Shortness of breath
Yes / No	Eye disease	Yes / No	Skin disease
Yes / No	Fainting spells	Yes / No	Spina bifida
Yes / No	Family history of diabetes	Yes / No	Stomach problems or ulcers
Yes / No	Fever	Yes / No	Stroke
Yes / No	Frequent urination	Yes / No	Thyroid disease
Yes / No	Frequent vomiting	Yes / No	Transplants
Yes / No	Headaches	Yes / No	Tuberculosis
Yes / No	Hearing problems, ear pain	Yes / No	Tumors or cancer
Yes / No	Heart attack	Yes / No	Urinary tract Infections

This information will not be released unless specifically authorized by patient.

Yes / No	Treatment for emotional, mental, or physical delays	Yes / No	Anxiety
Yes / No	AIDS/HIV	Yes / No	Depression

13. Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? Yes / No

14. If yes, explain:_____

15. Is there any issue or condition that you would like to discuss with the dentist in private? Yes / No

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Dental Health History

Patient Name (first, MI, last)**:**_____

16. Is this the patient's first dental visit? Yes / No **Please list the reason for the visit:**_____

17. Date of last dental examination:_____

18. Name of patient's previous dentist:_____

19. Reason(s) for leaving the patient's previous dentist:_____

20. Date of last dental radiographs (X-rays):

_____

21. Does the patient respond well to his/her pediatrician or past dentist: Yes / No **If no, please explain:**_____

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

Yes / No	Injuries to the face, mouth, or teeth	Yes / No	Habits (cheek biting, lip biting/sucking, tongue thrusting)?
Yes / No	Thumb, finger, or pacifier sucking? Until what age: __	Yes / No	Speech Problems?
Yes / No	Missing or extra permanent teeth?	Yes / No	Habit of going to be with a bottle?
Yes / No	Mouth breathing, snoring, enlarged adenoids or tonsils?	Yes / No	Jaw pain, clenching or grinding of teeth?

22. Do you live in a community with fluoridated water? Yes / No / Do not know

23. Does the patient drink tap water? Yes / No

24. Does the patient use any fluoride supplements (rinses, vitamins)? Yes / No **If yes, name of product:** _____

25. How often does the patient brush his/her teeth? _____

26. Does the patient floss his/her teeth? Yes / No **If yes, how often?** _____

27. Has the patient ever been evaluated for or had orthodontic treatment? Yes / No

28. If considering orthodontic treatment, what would you most like it to accomplish for the patient? _____

Authorizations

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact the patient's physician:

Responsible Party's Signature (Parent or Guardian):

_____Date:_____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my child's dentist of any change in my child's health and/or medication. Further, I will not hold my child's dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Responsible Party Signature (Parent or Guardian): _____ Date: _____

Dr. Kshama Kheny:_____

Medical Updates

I have reviewed my child's Health History and confirm that it accurately states past and present conditions.

Date	Parent Signature	Change to Health History	Dentist's Initials
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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CONSENT FOR SERVICES & OFFICE POLICIES

Financial and Insurance Policies:

It is our objective to provide our patients with the latest dental technology, superior dental materials and excellent care in a modern comfortable environment. I hereby give my approval and consent to start my dental treatment and assume complete financial responsibility for all services rendered. As a courtesy to our patients, we will file your dental insurance claims and bill your dental insurance company for treatments you receive. I understand that personal payments and/or insurance deductable & copayments are due at the time of service unless other prior arrangements have been made.

Please take the time to read and understand your insurance policy and benefits. In most cases, dental insurance is a contract between you and your dental insurance company. The benefits you receive are based on the terms of the contract that were negotiated between you and your dental insurance company, and not our dental office. Our goal is to help you achieve and maintain optimal dental care. Our office will do everything possible to help you understand and make the most of your dental insurance benefits. To the best of my knowledge, I am currently eligible for dental treatment through my insurance company. I also understand that, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.

Any account balance which is not on the payment plan and which is over 60 days old will have finance charges of 1.5% per month (18% APR) added. In the event that an account becomes past due over 90 days, it may be given to an outside collection agency, unless previously written financial arrangements have been agreed. As per our office policy, release of dental records (including digital XRays) will require a signed release form and is subject to a $25 fee.

Appointment Cancellation Policy:

We pride ourselves in providing extra time for the personal attention each patient deserves. Your appointment time in this office will be reserved for you. We respect your time and make every effort to keep you from waiting. We request you provide us with at least 48 hours notice if you need to reschedule your appointment. We reserve the right to charge patients who do not reschedule their appointments with adequate notice, or who fail to keep their scheduled appointments, an appropriate cancellation fee of $50/per hour applies for broken appointment.

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

_____ _____ _____

Patient's Name ***Signature of patient, parent or legal guardian*** ***Date***

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) took effect on April 14, 2003. This federal law requires our office to provide a notice of privacy practices. You may also request a paper copy. We appreciate you acknowledging having received our "Notice of Privacy Practices" with an effective date of 9-23-2013. This notice is also posed in the office and you may request another copy at any time.

_____

Signature for acknowledgement of receipt of NOTICE OF PRIVACY PRACTICES

Proposition 65:

The state of California, under proposition 65, now requires every dentist to give each of their patients a copy of the information relating to materials and techniques used in the dental environment. This information is contained in the attached document entitled "DENTALMATERIALS FACT SHEET". It is required that all patients sign they have received a copy of this document. We would appreciate you taking the time to sign the bottom of this form certifying you have received a copy of the DENTAL MATERIALS FACT SHEET. If you have any questions regarding information contained within the document please feel free to bring your questions to our attention.

_____

Signature for receipt of DENTAL MATERIALS FACT SHEET