



Registration Form

Name _____
(Last) (First) (MI)

Address: _____
(Street and number) (City & state)

(Zip code) (Phone number) (Date of birth) (Male/female)

County work/cell Social Security #

Method of Payment: Cash Visa MasterCard Insurance Medicaid

Carrier Name _____ Group No. _____

Employee/Subscriber name: _____

SS# _____

Date of Birth _____

Employer: _____

Group or Identification No. _____

Patient/Parent/Legal Guardian: _____
(Signature)

Patient/Parent/Legal Guardian: _____
(Please print)

Signature of Witness _____



Medical History

Name: _____

Date of Birth: _____ Age: _____

Patient's Disability: _____

Physician Name: _____ Ph# _____

Address: _____ City/State/Zip _____

Date of last medical visit: _____ Reason: _____

Medications:

Is patient allergic to any medications/foods/or other? Yes No If yes, please list below.

Has patient ever been hospitalized? Yes No If yes, give approximate year and reason.

To the best of my knowledge, all of the preceding answers are true and correct. If the patient has any change in his/her health history, or medications, I will inform the dentist at the next appointment.

(Patient/parent/legal guardian) (Date) (Dentist signature)

(Signature of Witness)

*** OFFICE USE ONLY BELOW THIS LINE ***

Date	Medical History Update	Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Medical History Form# 2

Name: _____ Age: _____ Date: ____/____/____

Check Y for "YES" or N for "NO" for any of the following you have had in the past or now have

CARDIOVASCULAR

- Heart failure Y N
- Angina or chest pain Y N
- High blood pressure Y N
- Heart murmur Y N
- Mitral valve prolapse Y N
- Rheumatic fever Y N
- Congenital heart defect Y N
- Artificial heart valve Y N
- Arrhythmias Y N
- Heart pacemaker/defibrillator Y N
- Heart surgery Y N
- Other heart problems Y N
- Stroke Y N
- Aneurysm Y N
- Shortness of breath Y N
- Swollen ankles Y N
- Sleep on 2 or more pillows Y N

HEMATOLOGIC

- Blood transfusion Y N
- Anemia Y N
- Hemophilia Y N
- Leukemia Y N
- Sickle cell disease Y N
- Bleeding tendencies Y N

NEUROLOGIC

- Glaucoma Y N
- Hearing loss Y N
- Sever headaches Y N
- Fainting or dizzy spells Y N
- Epilepsy Y N
- Seizures or convulsions Y N
- Psychiatric treatment Y N
- Paralysis Y N

GASTROINTESTIAN

- Stomach or intestinal ulcers Y N
- Gastritis / Colitis Y N
- Hepatitis Y N
- Liver disease Y N
- Yellow jaundice Y N
- Cirrhosis Y N

RESPIRATORY

- Hay fever Y N
- Sinus trouble Y N
- Allergies/hives Y N

Signature _____

- Asthma Y N
- Emphysema Y N
- Bronchitis Y N
- Tuberculosis (TB) Y N
- Breathing difficulties Y N

DERMATOLOGIC

- Allergy to latex rubber/metal Y N
- Skin rash Y N
- Fever blisters Y N
- Mouth ulcers/canker sores Y N

ENDOCRINE

- Diabetes Y N
- Thyroid disease Y N

GENITOURINARY

- Kidney problems Y N
- Diabetes Y N
- Sexually transmitted disease Y N
(Syphilis, Gonorrhea, Chlamydia, Herpes)

MUSCULOSKELETAL

- Arthritis Y N
- Artificial joints Y N
- Bone disorders Y N
- Muscle disorders Y N

OTHER

- HIV-Positive Y N
- Drug addiction Y N
- Alcohol addiction Y N
- Tumor or cancer Y N
- X-ray or cobalt treatment Y N
- Chemotherapy Y N
- Organ transplantation Y N
 - Kidney Y N
 - Heart Y N
 - Others (list) _____ Y N

- Use tobacco Y N
- Reaction to dental anesthesia Y N
- Reaction to general anesthesia Y N
- If yes, what type? _____

- Unexplained weight loss/gain Y N

WOMEN:

- Pregnant Y N
- Breast feeding (currently) Y N
- Use of oral contraceptives Y N

DENTAL HISTORY

Name: _____ Date: _____

▶ Is this his/her first dental visit? _____ if no, complete the following:

▶ Previous Dentist _____ Date of last visit _____

▶ What treatment was done? _____

▶ What was patient's reaction to visit? _____

▶ Last complete series of x-rays? _____

▶ Who brushes his/her teeth? _____ How often _____

▶ Does he/she recognize words such as: circle- mouth, teeth, open, close.

▶ Does he/she exhibit any of the following habits? Yes or no

Thumb sucking _____ finger biting _____

Rocking or fidgeting _____ physical resistance _____

▶ Does he/she use specific methods of communication other than speech to express needs and desires? _____

▶ How do you encourage or reward good behavior at home?

▶ Does he/she respond favorably to physical contact and reassurance from family members? _____

▶ Is there any additional information that might help us in treating the patient?



CONSENT FOR TREATMENT

I consent to general dental treatment for myself/minor child which in the judgment of the dentist is necessary for oral health. This treatment may include but is not limited to the following: restoration of teeth, extracting of teeth, x-rays, administration of drugs/local anesthetics, root canals, periodontal treatment, prosthetics, oral surgery and other specialty treatments deemed necessary. I approve the release of my records to my insurance/Medicaid or other dentists as deemed necessary by the dentist. I authorize you to verify employment, financial or medical history, and other related matters as may be necessary to determine eligibility. I authorize the dentist to file claims and receive reimbursement directly from Medicaid/Peachcare for Kids. I understand that this request for dental treatment is valid for as many years as my child is eligible, by the program policy, for this service. This permission can be revoked only by written notification to:

DDD Foundation, Inc
52 Executive Park South, Suite# 5203, Atlanta, Ga. 30329

I further verify that the above medical history is true and accurate to the best of my knowledge.

Date: _____ Patient: _____

Signature: _____
 (Relationship to Patient)

 (Witness) (Relationship)

Verbal Consent Given By: _____

For all treatment: _____

Consent for Physical Restraints

“Physical Restraint by Dentist/Assistants: The restraining of the patient from undesirable movement by stabilizing the patient’s hands, upper body, head and leg movements with the intention of preventing injury to the patient and dental staff.”

It is our intent that all professional care delivered in this office shall be of the best possible quality we can provide for our patients. Providing a high quality of care can sometimes be made very difficult, or even impossible, due to a lack of cooperation from the patient. The following behaviors that can interfere with the proper provision of quality dental care include: hyperactivity, resistive movements, refusing to open the mouth, kicking, screaming and grabbing the dentist’s hands or sharp instruments.

I hereby give my consent to Dr. Deidra T. Rondeno, assisted by other dentists and/or dental auxiliary, to use physical restraints including, but not limited to: a mouth prop, Posey restraint jacket, soft wrist restraints, leg and head restraints as an essential part of efforts to render mutually agreed upon dental services for the patient. I further agree that this consent shall remain in full force unless withdrawn in writing by the person who has signed below on behalf of the patient.

Parent/Legal Guardian: _____ Date: _____

Witness: _____ Date: _____



Financial Policy

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Feel free to ask about our fees, Financial Policy, or your financial responsibility.

If you have dental insurance, we will help you receive your maximum allowable benefit. Dental insurance is a contract between you and your insurance company. It is our responsibility to understand the extent and limits of your coverage. It is not our place to enter into disputes between you and your insurance company regarding your benefits, other than to provide factual treatment information. Our staff will help you process whatever paperwork is required however; the ultimate responsibility lies with you for any balance due.

WE ARE NOT A PARTICIPANT OF ANY DENTAL PLAN EVEN THOUGH YOUR REFERRING DENTIST MAY VERY WELL BE AND HAS REFERRED YOU TO OUR OFFICE FOR TREATMENT.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT. RETURNED CHECKS AND BALANCES OLDER THAN 60 DAYS WILL BE SUBJECT TO ADDITIONAL COLLECTIONS FEES. A SERVICE CHARGE OF 1.5% PER MONTH WILL AUTOMATICALLY BE ADDED TO DELINQUENT ACCOUNTS. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

My signature below indicates that I have read and understand the financial policy as stated above and agree to accept responsibility as described. I understand that regardless of my insurance status, I am ultimately responsible for payment of my account.

Name

Phone Number

Address / City / State / Zip

Social Security #

DOB

Signature of responsible party

Date



MOTOR SKILLS QUESTIONNAIRE

Name: _____ Date: _____

Language spoken: _____

Physical Coordination:

Sitting: none___ poor___ fair___ good___

Speech: none___ poor___ fair___ good___

Vision: none___ poor___ fair___ good___

Walking: none___ poor___ fair___ good___

Balance: none___ poor___ fair___ good___

Hearing: none___ poor___ fair___ good___

Grasping: none___ poor___ fair___ good___

Standing: none___ poor___ fair___ good___

Is patient in a wheel chair: Yes _____ No _____

Neurologist: _____ Ph: _____

Cardiologist: _____ Ph: _____

Pharmacy: _____ Ph: _____

Allergies: _____

Weight: _____