CARROLL DENTAL ASSOCIATES
CARROLL IOWA

CHILD'S REGISTRATION

PLEASE PRINT

Today's Date

Child's Information

Child's Last Name	First Name	MI	Preferred Name	Social Security #

Gender ❑ Male ❑ Female	Date of Birth	Current Age	Grade	School

Child's Address	City	State	Zip	Home Phone

Parent's Information

Mother's Name	Circle One: Mother/Stepmother/Guardian	Date of Birth	Social Security #

Address	City	State	Zip	Driver's License Number	Home Phone

Employer	Work Phone	Cell Phone	Email

Father's Name	Circle One: Father/Stepfather/Guardian	Date of Birth	Social Security #

Address	City	State	Zip	Driver's License Number	Home Phone

Employer	Work Phone	Cell Phone	Email

Who is the responsible party? Name: _____ Relationship: _____

Who is accompanying the child today? Name: _____ Relationship: _____

Name of person with legal custody of the child: _____

How did you hear about us? Friend Family Internet Phone Book Referring Dr: _____ Other: _____

Names and ages of other children in the family: _____

Emergency Contact (Other Than Parents)

Last Name, First Name, MI	Relationship	Home Phone	Other Phone

DENTAL INSURANCE INFORMATION

Primary Insurance Co. Name		Secondary Insurance Co. Name	
Name of Policy Holder		**Name of Policy Holder**	
Policy Number/Social Security Number	**Group Number**	**Policy Number/Social Security Number**	**Group Number**
Policy Holder's Number	**Policy Holder's Birth Date**	**Policy Holder's Number**	**Policy Holder's Birth Date**

CHILD'S HEALTH HISTORY

Child's Name:	Date:

CHILD'S MEDICAL DOCTOR/PHYSICIAN

Name	Phone	Fax
Address	**Date of Last Visit**	**Reason**

Does your child have any ALLERGIES to any foods/medications/material (ex. Latex)? YES NO If yes, please list and explain the reaction: _____

If your child currently taking any medications? YES NO If yes, please list: _____

_____

Does your child require antibiotics for dental work? YES NO If yes, please explain: _____

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH OR HAD ANY OF THE FOLLOWING PROBLEMS?	NO	YES (If Yes, Please Explain)
Abnormal Bleeding		
Anemia (List type _____)		
Asthma		
Autism		
Birth Defects		
Bone/Joint Problems		
Blood Transfusion		
Cancer/Tumors		
Chemotherapy/Radiation		
Cerebral Palsy		
Cleft Lip/Cleft Palate		
Congenital Heart Disease		
Development Delay		
Diabetes		
Down Syndrome		
Hearing/Speech Impairment		
Heart Murmur/Defect		
Heart Surgery		
Hemophilia		
Hepatitis		
HIV+/AIDS		
High Blood Pressure		
Hospitalizations (Overnight stays)		
Hyperactivity - ADHD/ADD/ODD		
Kidney/Liver Problems		
Mental Illness/Psychiatric Care		
Seizures/Convulsions/Epilepsy		
Surgeries/Operations		
Syndrome (Please list) _____		

Any other disease, illness, past surgeries, or health concerns not listed above? _____

_____

_____

CHILD'S DENTAL HEALTH

Child's Name:	Date:

REASON FOR SEEKING TREATMENT?

DENTAL HISTORY

Is this your child's first dental visit? YES NO If no, who was their previous dentist?_____

How long since the last dental visit? _____

Were any x-rays taken at previous visit? YES NO

Has your child ever received injuries to the teeth, face or mouth YES NO If yes, please explain: _____

_____

Does your child have a history of a thumb, finger or pacifier habit? YES NO _____

Does your child have a history of breast feeding? YES NO If yes, how long?_____ **or bottle feeding? YES NO**
If yes, how long? _____

Has your child ever had an unpleasant dental experience? If yes, please explain: _____

_____

_____

Has your child had any recent dental pain? YES NO If yes, please explain: _____

HOME DENTAL CARE

How often does your child do the following? brush_____ **(times per day) and floss**_____ **(times per week)**

What kind of toothpaste is used? _____

Does your child receive help brushing and flossing? YES NO If yes, who is the primary helper? _____

Does your child drink well water, bottled water or city water? _____

DIET

Was/is your child put to bed with a bottle? YES NO If yes, what was/is in the bottle?_____

Was/is your child allowed to carry a bottle or cup throughout the day containing something other than plain water? YES NO

How many meals per daydoes your child eat? _____ **How many snacks does your child have per day?**_____

Please list some favorite/frequent snacks: _____

and drinks:_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I request and authorize the dentists of Carroll Dental Associates and their staffs to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the dentist to diagnose and/or treat my child's dental problems. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes.

_____ _____

Signature of Parent or Guardian Date

CARROLL DENTAL ASSOCIATES
CARROLL IOWA

ASSIGNMENT OF BENEFITS

I voluntarily direct _____ Insurance company (or Attorney at Law) to pay members of Carroll Dental Associates (Dr. Karl Eischeid, Dr. Nicholas Fangman, Dr. Marie G'Sell, Dr. Martin Halbur and Dr. Michelle Sturm) directly for charges for professional services rendered to me. THIS IS A DIRECT ASSIGMENT OF BENEFITS UNDER THIS POLICY. I agree that I am responsible for any balance over and above insurance/attorney payments for these services. I understand and agree that if collection efforts are necessary to obtain payment on this account, I will be responsible for all costs of such collection efforts, including reasonable attorney fees.

I UNDERSTAND THAT ANY UNPAID BALANCE WILL ACCRUE MONTHLY INTEREST AT 1.5 % AFTER 30 DAYS OF DELINQUENCY, UNLESS PRIOR PAYMENT ARRAGNEMENTS ARE MADE.

CONSENT TO TREAT

I voluntarily authorize members of Carroll Dental Associates and whomever Dr. _____ designates as assistants or associates to administer examinations and care as deemed necessary for my condition.

APPOINTMENTS

Any missed appointments without 24 hours notice, except in an emergency, will be documented. Multiple missed appointments will lead to dismissal from the practice.

PATIENT OR PARENT/GUARDIAN
SIGNATURE_____

DATE _____

CARROLL DENTAL ASSOCIATES
CARROLL IOWA

Karl J. Eischeid DDS, Nicholas J. Fangman DDS, Marie C. G'Sell DDS, Martin J. Halbur DDS, Michelle N. Sturm DDS

Receipt of Notice of Privacy Practices

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* You May Refuse to Sign This Acknowledgment *

I have been offered a copy of this office's Notice of Privacy Practices effective January 1st, 2014.

Print Patient Name: _____

Signature of Patient or Person Authorized to Consent: _____

Patient's Relationship to Authorized Person: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❏ Individual refused to sign
- ❏ Communications barriers prohibited obtaining the acknowledgement
- ❏ An emergency situation prevented us from obtaining acknowledgement
- ❏ Other (Please Specify)