Cornerstone Kids Dentistry
332 Suffield Street, Agawam, MA, 01001
413-786-0077

PATIENT REGISTRATION

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Date of Birth: _____ Age: _____ SSN: _____

Sex: ☐ Male ☐ Female Prefer not to say **Preferred Name:** _____

Patient is: ☐ **Policy Holder** ☐ **Responsible Party**

-----Responsible Party Information------

Address: _____ **Address 2**: _____

City: _____ **State/Zip** _____

Sex: ☐ Male ☐ Female **Marital Status:** ☐Married ☐Single ☐Divorced ☐Seperated ☐Widowed

Date of Birth: _____ **PARENT/LEGAL GUARDIAN SSN:** _____

Home Phone: _____ **Cellular:** _____ Work: _____

Email Address: _____@_____

☐ I would like to receive correspondences via e-mail ☐ I would like to receive correspondences via texting

We now text & Email confirmations and reminders! How would you like your reminders set?
(Please check which ones you would like to receive. These can ALWAYS be adjusted to more or less.)

☐1 month before scheduled appointment ☐ 1-2 weeks before ☐1-2 days before ☐ Same day reminder

-----Insurance Information------

Policy Holder:

First Name: _____ Last: _____ Middle Initial: _____

Policy Holder's DOB: _____ Patient Relationship: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Employment Status: ☐ Full Time ☐ Part Time ☐ Per Diem ☐ Retired

Employer's (Place of employment) Name: _____

Insurance Company: _____ Effective Date: _____

Policy ID # (may be Policy holder's SSN) _____ Group #: _____

-----Secondary Insurance/Medical Insurance-----

First Name: _____ Last: _____ Middle Initial: _____

Policy Holder's DOB: _____ Patient Relationship: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

Employment Status: ☐ Full Time ☐ Part Time ☐ Per Diem ☐ Retired

Employer's (Place of employment) Name: _____

Insurance Company: _____ Effective Date: _____

Policy ID # (may be Policy holder's SSN) _____ Group #: _____

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MEDICAL HISTORY FORM

Child's First Name: _____ Last Name: _____ Middle Initial: _____

Name/Phone # of primary physician: _____

Date of last physical examination: _____/_____/_____

Please list the name and location of your child's preferred pharmacy: _____

Is your child under a physician's care currently, other than general care? YES| NO

Please list all medical problems, hospitalizations, surgeries your child has had: _____

_____

Does your child take any medications, vitamins, dietary supplements at this time? If so, please list and give reasons: _____

_____

Does your child have a history of allergies/adverse reactions to any drugs or medications such as penicillin, novocain, etc. If yes, please list and describe: _____

Is your child up to date on immunizations? YES | NO if not, specify _____

Does your child have a physical or medical disability/delay that we need to be aware of? Please describe:_____

_____

Has your child had any sedation/general anesthesia complications? YES | NO if yes, specify _____

Does your child require premedication prior to dental treatment? Yes/No, if yes please list why: _____

FEMALES: Are you…

☐ Taking oral contraceptives? ☐ Pregnant? ☐ Nursing?

Is your child allergic to any of the following?

☐ Acrylic	☐ Eggs	☐ Peanut Allergy	☐ Aspirin
☐ Latex	☐ Seasonal Allergies	☐ Codeine	☐ Local Anesthetics
☐ Sulfa	☐ Dairy	☐ Metal	☐ Shellfish
☐ Dyes	☐ Penicillin		

Is your child allergic to any of the following?

	Y	N		Y	N		Y	N		Y	N
Abuse|Neglect	☐	☐	Acid Reflux	☐	☐	ADD|ADHD	☐	☐	AIDS|HIV	☐	☐
Anemia|sickle cell	☐	☐	Arthritis|Scoliosis	☐	☐	Asthma	☐	☐	Autism	☐	☐
Bladder|Kidney Issues	☐	☐	Chemotherapy	☐	☐	Cancer|Lukemia	☐	☐	Celiac Disease	☐	☐
Cerebal Palsy	☐	☐	Down Syndrome	☐	☐	Chronic ear infec.	☐	☐	Develop Delays	☐	☐
Diabetes	☐	☐	Fainting spells	☐	☐	Eating disorder	☐	☐	Epilepsy|Seizures	☐	☐
Excessive bleeding	☐	☐	Impaired vision	☐	☐	Headaches	☐	☐	Hearing Impair.	☐	☐
Hemophilia|bruising easily	☐	☐	Nurtional Deficiency	☐	☐	Heart disease|Mumur	☐	☐	Liver issues|Jaundice	☐	☐
Low|High blood pressure	☐	☐	Psychiatric disorders	☐	☐	Pain in jaw joints	☐	☐	Precocious Puberty	☐	☐
Premature birth	☐	☐	Snoring|mouth breathing	☐	☐	Rash|Hives|Eczema	☐	☐	Sensory issues	☐	☐
Sinus problems	☐	☐				Thyroid problems	☐	☐	Tobacco|Alcohol| Drug Issues	☐	☐

Does your child have any serious illness that is not listed above? YES | NO, If yes please specify: _____

_____

Parent/Guardian Signature: _____ Todays Date: _____

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MEDICAL HISTORY CONT.

Childs Name: _____ DOB: _____

Why is your child here today? (first exam/visit, routine checkup, toothache, injury, etc.) _____

How often does your child brush his/her teeth?

How often does your child floss his/her teeth?

Is brushing/flossing supervised by an adult? YES | NO
Is/was your child:
◯ Breast-fed, until what age?
◯ Bottle-fed, until what age?
Does your child go to bed with a bottle/sippy cup?
Yes, it contains _____ No
Does your child use a sippy cup or a straw? YES| NO
Is your child's water fluoridated? YES | NO | UNSURE
Is your child receiving fluoride supplements? YES | NO
Is this your child's first dental visit? YES| NO
If your child had a previous dentist, please list
Name & City: _____
Date of last dental visit: _____
Date of last dental x-rays: _____
Has your child experienced any unfavorable reaction from previous medical or dental care? YES | NO
If yes, please explain: _____
_____

How do you expect your child will respond to dental treatment?
◯ Very well ◯ Fairly well ◯ Somewhat poorly

Please check all your conditions that your child has or had in the past and explain:
____ Mouth sores
____ Bleeding gums
____ Cavities/toothache
____ Injury to teeth, mouth or jaws
____ Grinding/jaw pain
____ Thumb/finger sucking
____ Pacifier use
____ Mouth breathing/snoring
Is your child on a special or restricted diet? YES | NO
If yes, specify: _____
Does your child snack frequently? YES |NO
How often does your child drink juice, soda, or sports drinks? ◯ Never ◯ 1x/day ◯ 2-3x/day ◯ >3x/day

Does your child participate in any sports or similar activities? YES | NO, If Yes, list _____
Does your child wear a mouth guard during these activities? YES | NO
Is there anything we should know before treating your child? _____

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 that it is my responsibility to inform this office of any changes in my child's medical status.

_____

Signature of parent/legal guardian **Date**

OPTIONAL: *Photo Release Consent: I hereby give my consent for Cornerstone Kids Dentistry to use my child's photograph on the company's website and/or social media page. Pursuant to the law, Cornerstone Kids Dentistry will not release any personal identifiable information about my child's (such as last name). I attest that I am the parent or guardian of the child. I have read this release and approve of its terms. I hereby freely and voluntarily consent to the use of my child's photograph as stated above until I revoke this consent in writing.*

_____

Signature of parent/Legal guardian **Date**

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INFORMED CONSENT FOR PEDIATRIC DENTISTRY

It is your right, as a parent, to understand the risks, benefits, and alternatives of your child's dental treatment, and to accept or refuse treatment offered to your child. Please read this form carefully and ask about anything you do not understand.

EXAMINATION

Every child is a unique individual and thus not every child will require the same treatment to obtain a comprehensive oral examination. Based upon your child's age, teeth present, and tooth position, the doctor and staff will determine if radiographs (x-rays) are necessary. In general, the examination appointment also includes cleaning of the teeth and application of topical fluoride. If you have any questions or concerns about our examination procedure, please ask one of our staff.

TREATMENT

If your child should need any dental treatment after the dental examination has been completed, the doctor will review the planned treatment with you. Please read the following information regarding dental treatment at our office.

It is our policy that all treatment options are explained to the parent(s) and or guardian, including treatment alternatives, advantages and disadvantages of each. Although good results are expected, it is not possible to guarantee success due to the possibility of complications.

Risks that occasionally associated with dental treatment procedures include: numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reaction and infection.

If my child requires dental treatment, I will be advised of the benefits, risks, and possible side effects if proposed treatment, and possible consequences of not receiving the treatment. Treatment alternatives, including no treatment, will be presented to me and all my questions regarding my child's care will be answered satisfactorily. With my signature I authorize Cornerstone Kids Dentistry to perform a dental exam of my child and agreed upon treatment. I acknowledge that I have reviewed the possible risks and complications associated with dental treatment.

Child/Patient Name: _____ DOB: _____
(PRINTED)

Parent/Guardian Signature: _____ Date: _____

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INSURANCE DISCLOSURE FORM

Insurance fraud hurts you and your child/children, and can subject you to criminal and civil penalties. Due to the serious nature of this offense and because this conduct may increase the exposure and expenses incurred by this office, we must enforce this policy.

PLEASE ENSURE you have notified our front desk staff of all insurance plans your child/children is enrolled in, including **PRIVATE** and **STATE** insurance.

If Insurance fraud is discovered after signing this form, Cornerstone Kids Dentistry is entitled to:

- Administrative fee of $500
- Payment for any monetary difference between signed treatment plan and changes that result from new insurance information.
- Refuse services and deactivate patient(s) from the office.
- Report of fraud to the proper authorities.

I, _____, the legal guardian and/or parent of the minor child/children listed below have read and understand the insurance coverage form. Further, I have disclosed any and all forms of private and state funded insurance available for the minor child/children to Cornerstone Kids Dentistry.

Child Name (1) _____ DOB: _____

Child Name (2) _____ DOB: _____

Child Name (3) _____ DOB: _____

Child Name (4) _____ DOB: _____

Parent/Guardian Signature _____ Date: _____

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ABSENCE OF A LEGAL PARENT/GUARDIAN
Child Health History Update Authorization

We require an updated health history form at each child's visit prior to treatment. It is important that we are aware of any changes in your child's health.

In the event that the parent or legal guardian is unable to attend and a child comes in with a chaperone, we require permission to have this person complete the health history form on your child's behalf.

Accordingly, please complete the following for any individuals other than the parent/legal guardians who may bring your child to any appointments:

Chaperone (1) Name: _____ Relation to Child: _____

Chaperone (2) Name: _____ Relation to Child: _____

I authorize the doctor and staff of Cornerstone Kids Dentistry to accept the above mentioned individual(s) on my behalf, to complete the health history form for my child. Treatment plans, exam feedbacks, and any questions may be asked of the individual(s) listed and decisions made provided in my absence are supported. **OR**, I wish to be contacted PRIOR to any changes or additions made to my child(s) proposed treatment at:

.: PLEASE LIST THE BEST NUMBER TO CONTACT YOU: (_____) _____

If we are unable to reach you within 5-10 minutes of this initial attempt, we will reschedule the appointment until we can obtain the authorization for treatment.

I understand that I may revoke this authorization in writing at any time.

Child's Name (PRINT) _____ DOB: _____

Parent/Guardian (PRINT) _____ DATE: _____

Parent/Guardian (Signature) _____

Witness Signature _____ DATE: _____

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WRITTEN OFFICE POLICIES

Thank you for choosing Cornerstone Kids Dentistry. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Initial the following Statements.

_____1. **PAYMENT OPTIONS:**

You can choose from:

- Cash, Check, Visa, Discover or MasterCard
- **NO INTEREST** Payment plans from Care Credit *(you can ask for more information at the front desk)*
  - Allows you to pay over a period of time with **NO INTEREST**
  - Convenient, low monthly payment plans also available
  - No annual fees ore pre-payment penalties

_____2. **INSURANCE COVERAGE:**

It is simply not possible for our staff to know all the details of every individual insurance plan. It is the patient's responsibility to verify the following before your appointment.

- Our office participates with your insurance plan and you are in-network or you are allowed to go to an out-of-network office
- Any co-payments, co-insurances, or deductibles that may be due at the time of service.
- For patients with dental insurance, we are happy to work with your carrier to maximize your benefits and directly bill them for reimbursement for your treatment.

_____3. **COVERAGE CHANGE:**

Please notify our office of any changes to your insurance coverage. If your coverage was not in effect at the time of your visit, you will be responsible for payment in full. Please also refer to our Insurance Disclosure Form.

_____4. **MISSED APPOINTMENTS:**

If you need to cancel or reschedule an appointment, please contact our office at least 48 hours prior to the appointment time or a fee will be charged to your account.

- Two (2) consecutive missed/rescheduled appointments without sufficient notice OR three (3) within a twelve (12) month period are grounds for immediate patient termination from the practice.

_____5. **RETURNED CHECKS:**

Cornerstone Kids Dentistry will charge $25.00 for returned checks

Payment terms:

PLEASE remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. The patient and or responsible party agrees to pay **INTEREST** at the rate of 1.1/2% per month and all cost of collections, including reasonable attorney fees, on all amounts due on account more than 30 days from the date of service or final payment of insurance on the date of service. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I further herby assign all dental benefits, to which I am entitled, including, private insurance, and other health plans to: **Cornerstone Kids Dentistry**. Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I further give permission to pull a credit report as needed should my account be turned over to an outside source for collection efforts. I understand that all dental procedures performed by the doctor are necessary and waive any defense to the contrary.

Child's Name (PRINT) _____ DOB: _____

Parent/Guardian (PRINT) _____ DATE: _____

Parent/Guardian (Signature) _____

Witness Signature _____ DATE: _____

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Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

[Last updated June 2022]
Cornerstone Kids Dentistry
332 Suffield Street
Agawam, MA 01001

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy at **Cornerstone Kids Dentistry's**

HIPAA Notice of Privacy Practices.

I understand that **Cornerstone Kids Dentistry's** HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Cornerstone Kids Dentistry's revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about Cornerstone Kids Dentistry's HIPAA Notice of Privacy Practices, I may contact Cindy at 413-786-0077.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that **Cornerstone Kids Dentistry** will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding **Cornerstone Kids Dentistry's** privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services. Please ask for Cindy, noted above, for assistance.

Patient Name (PRINT) _____ DOB: _____

Patient Signature _____ Date: _____

Patient Representative (PRINT) _____ Date: _____

Signature of Representative _____ Relationship _____

FOR OFFICE USE ONLY

Cornerstone Kids Dentistry made a good-faith effort to obtain Acknowledgement from the patient noted above, of receipt of its HIPAA Notice of Privacy Practices. In spite of these efforts, Cornerstone Kids Dentistry was unable to obtain a signed Acknowledgement for the following reason(s):

- Refusal to sign Acknowledgment on _____, 20 _____.
- Communication barriers prohibited us from obtaining a signed Acknowledgement.
- An emergency situation prohibited us from obtaining a signed Acknowledgement.
- Other (Describe): _____.

FOR OFFICE USE ONLY

Date Received: _____ BY: _____

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AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

[Last updated June 2022]
Cornerstone Kids Dentistry
332 Suffield Street
Agawam, MA 01001

Your decision to sign this Authorization is voluntary. **Cornerstone Kids Dentistry** will not refuse treatment to you if you refuse to sign this Authorization.

When your protected health information is released as provided by this Authorization, please be aware that the named recipient (above) may not be legally obligated (under HIPAA) to obtain an authorization for subsequent re-disclosure of your protected health information.

PATIENT SIGNATURE

I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this Authorization, I am permitting **Cornerstone Kids Dentistry** to release, use or disclose my protected health information

Patient Name **(PRINT)** _____ DOB: _____

Patient Signature (if applicable) _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if child is under the age of 18yrs)

REPRESENTATIVE SIGNATURE

I affirm that I am the personal representative of the patient noted above and that I have the authority to authorize the release, use or disclosure of the patient's protected health information on his/her behalf. I have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use of disclosure the patient's protected health information.

Patient Name (PRINT) _____ DOB: _____

Parent/Guardian Signature: _____ Date: _____

Relationship to Patient _____ Date: _____

◯ Parent ◯ Guardian ◯ Power of Attorney

FOR OFFICE USE ONLY

Date Received: _____ BY: _____

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OPEN DOOR POLICY

We invite parents to stay with their child during their dental appointments. As your child gets more comfortable with us, we encourage you to allow them to be independent if they wish.

We kindly ask that you please respect the limited size of our treatment areas and choose ONE ADULT to stay with the child if they are not ready to be on their own. To ensure everyone's safety, other children must remain in the waiting areas (unless they are in a car seat.) Children younger than 12 years of age must be under the supervision of an adult in the waiting room. Our front desk staff are unable to monitor your child(ren) in the waiting room.

If you choose to accompany your child, we kindly ask that you assume the role of a **SILENT OBSERVER**, *please see the attached handout*. This allows us to focus all of our attention on your child, and vice versa. Some children do perform better when a parent isn't present in the treatment room. If this is found to be the case, the doctor will discuss different methods to help your child master the dental appointment.

As a general guideline, we caution parents about using words that may make your child unnecessarily fearful or anxious, such as shot, needle, drill, x-ray, pull, scary, painful, hurt or blood.

Thank you in advance for observing these guidelines. We look forward to working with you and your child!

Child's Name (PRINT) _____ DOB: _____

Parent/Guardian (PRINT) _____ DATE: _____

Parent/Guardian (Signature) _____

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REQUEST FOR DENTAL RECORDS

Child's Name (PRINTED): _____DOB: _____

Previous Office Name: _____

Previous Office Number: _____

I, _____ am requesting all of my records (x-rays and necessary notes) to be forwarded to Cornerstone Kids Dentistry.

Cornerstone Kids Dentistry

332 Suffield Street

Agawam, MA 01001

Please email radiographs to: Cornerstonekidsdentistry@gmail.com

Parent's Name (PRINTED): _____

Parent Signature: _____ Date: _____