Cornerstone Kids Dentistry

# Patient Registration

## Patient (Child) Information:

First Name:_____ Last Name:_____MI:_____

Sex: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Age: _____ Nickname: _____

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## Responsible Party (Parent/Legal Guardian information):

First Name:_____ Last Name:_____MI:_____

Address:_____ Apt/Unit #_____

City, State, Zip:_____

Home Phone_____ Cellular Phone:_____

Birth Date: ____/____/_____ Soc Sec #:_____ Relationship to Patient_____

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## Primary Insurance Information:

Name of Insured:_____ Relationship to child:_____

Insured DOB: ____/____/_____ Policy ID:_____ Insured Soc Sec:_____

Home Address:_____ Apt /Unit #_____

City, State, Zip: _____Phone:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

City,State,Zip:_____ City,State,Zip: _____

## Secondary Insurance Information: (If Any)

Name of Insured:_____ Relationship to child:_____

Insured DOB: ____/____/_____ Policy ID:_____ Insured Soc Sec:_____

Home Address:_____ Apt /Unit #_____

City, State, Zip: _____Phone:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

City,State,Zip:_____ City,State,Zip: _____

Cornerstone Kids Dentistry

# MEDICAL HISTORY FORM

Child's First Name: _____ Last Name: _____ MI:_____

Primary Care Physician: _____ Phone: _____

Date of last physical exam: _____/_____/_____

Is your child up to date on **immunizations**? YES / NO if not, specify_____

Preferred Pharmacy: _____Location:_____

Is your child under a Specialist's care currently, other than general care? (Please circle) Yes / No

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

_____

List any **medications**, **vitamins**, **dietary supplements** your child takes at this time & reason: _____

_____

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

_____

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,specify:_____

**Is your child ALLERGIC to any of the following? (Please Circle ALL that apply)**

| | | | |
|---|---|---|---|
| Acrylic | Eggs | Peanut / Tree Nut | Aspirin |
| Latex | Seasonal Allergies | Codeine | Local Anesthetics |
| Sulfa | Dairy | Metal | Shellfish |
| Dyes | Penicillin/Amoxicillin | Other:_____ | |

**Does your child have any of the following? Please check any that apply**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Abuse/Neglect | | Cancer/Leukemia | | Excessive Bleeding | | Pain in Jaw Joints | |
| Acid Reflux | | Celiac Disease | | Impaired Vision | | Precocious Puberty | |
| ADD/ADHD | | Cerebral palsy | | Headaches | | Premature Birth | |
| AIDS/HIV+ | | Down Syndrome | | Hearing Impairment | | Snoring | |
| Anemia/Sickle Cell | | Chronic Ear Infections | | Hemophilia/Bruises easily | | Mouth Breathing | |
| Arthritis/Scoliosis | | Developmental Delays | | Nutritional Deficiency | | Rash/Hives/Eczema | |
| Asthma | | Diabetes | | Heart Disease/Murmur | | Sensory Issues | |
| Autism | | Fainting Spells | | Liver issues/Jaundice | | Sinus Problems | |
| Bladder/Kidney issues | | Eating Disorders | | Low/High blood pressure | | Thyroid Problems | |
| Chemotherapy | | Epilepsy/Seizures | | Psychiatric Disorders | | Tobbacco/Alchol/Drug Issues | |

Any serious illness that is not listed above? Yes / No, if yes please specify:_____

**Parent/Guardian Signature**:_____Todays Date:_____

Cornerstone Kids Dentistry

# MEDICAL HISTORY CONT.

Child Name:_____ DOB:_____

Why is your child here today?(first 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 conditions that your child has or had in the past and explain:
___ Mouth Sores
___ Bleeding gums
___ Cavities/toothache
___ Injury to teeth, mouth or jaw
___ Grinding/jaw pain
___ Thumb/finger sucking
___ Pacifier use
___ Mouth breathing / snoring
Is your child on a special or restricted diet? Y /N
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 __>3xday
Does your child participate in sports or similar activities? No / Yes, list_____
Does your child wear a mouth guard during these activities? Yes / No

Is there anything else 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**

Cornerstone Kids Dentistry

332 Suffield St, Agawam, MA 01001

# 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 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 are occasionally associated with dental treatment procedures include; numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions and infection.

If my child requires dental treatment. I will be advised of the benefits, risks, and possible side effects of 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: _____/_____/_____

Cornerstone Kids Dentistry

332 Suffield St, Agawam, MA 01001

# 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.

To ensure that we provide the best care and avoid any billing issues, it is essential that you notify us **immediately** if there are any changes to your insurance coverage. **Not doing so could result in unnecessary charges to you financially.**

**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 $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.

**Why reporting changes is important:**

- **Accurate Billing**: If we do not have your most current insurance information it could result in delayed or incorrect billing**, resulting in you being financially responsible for any visit**.
-
- **Avoiding Coverage Gaps**: Changes to your coverage, such as plan updates or changes to your benefits, could impact your treatment costs and services covered.
-
- **Timely Processing**: By informing us of any updates **PRIOR** to your visit, we can ensure smooth processing of claims and prevent any unexpected costs to you.

I, _____, the legal guardian/ or parent of the minor child named 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 to Cornerstone Kids Dentistry.

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

Parent/Guardian Signature:_____ Date: _____/_____/_____

Cornerstone Kids Dentistry

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# ABSENCE OF A LEGAL PARENT/GUARDIAN
## Child Health History Update / Financial Responsibility

We require updated health history information 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 a chaperone will be accompanying your child to their dental visit, it's important that they are able to relay pertinent health information. This includes any relevant medical history, allergies, or other details that may impact the treatment or care provided during the visit.

**Please ensure that this chaperone is familiar with this information and can communicate it clearly to our dental team**. **The chaperone must be at least 18yrs of age**.

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. Treatment plans, exam feedbacks and any questions may be asked of the individual(s) listed and decisions made in my absence are supported.

Please note that **payment for services rendered** is **DUE AT TIME OF APPOINTMENT**. If the above named chaperone(s) accompanies your child to their appointment on your behalf, they will be responsible for handling the payment for the visit.
We kindly ask that you ensure anyone attending in your place is aware of this responsibility before the appointment.

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:_____

Cornerstone Kids Dentistry

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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. You can choose from: Cash, Check, Visa, MasterCard, Discover or Care Credit

***INITIAL*** the following statements:

_____1. **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 the appointment.

- Insurance is active and there are remaining benefits.
- Our office participates with your insurance plan and you are in-network or you are allowed to go to an out-of-network office.
- Your estimated patient portion for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your patient portion may be adjusted after the time of service depending upon the final reconciliation of insurance payments. IF PATIENT PORTION CANNOT BE PAID AT THE TIME OF SERVICE, THE APPOINTMENT WILL BE RESCHEDULED

_____2. **Coverage Change:** Please notify our office of any change 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.

____3. **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 of $35.00. A missed/cancelled/rescheduled visit without sufficient notice of **48** hours may be grounds for termination from the practice and may only be rescheduled at our discretion. . A missed 1st appointment will **NOT** be rescheduled

____4. **Late Arrival**: Punctuality is important to ensure that we can provide you with the best possible service. Please be aware that we require all patients to arrive on time for scheduled appointments. If you are late, we may need to reschedule the appointment to avoid delays for others. Repeated late arrivals, may result in dismissal from the practice.

____5. **Returned Checks**: Cornerstone Kids Dentistry will charge $25.00 for returned checks

### ***Payment terms*:**

____1.Insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charges. Some have annual caps or multiple levels of coverage. Please understand that the payment of your bill is your legal obligation. It is also YOUR responsibility to determine which providers are covered under your current insurance. Notification of change of insurance carrier or level of coverage (e.g. PPO) is YOUR responsibility, as is any change of address / phone number.

____2. In the event that your account should become delinquent and is therefore placed in the hands of an Attorney/ Collection Agency for collection, you agree to pay attorney fees plus all court costs, and interest. Interest is charged at a rate of 1.5% per month, on amounts due on account more than 30 days from date of service or final payment of insurance. 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 hereby 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) _____

Parent/Guardian (Signature) _____ Date:_____

Cornerstone Kids Dentistry

332 Suffield St Agawam, MA 01001

# PATIENT HIPAA CONSENT FORM

(Last updated 2022)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day-to-day healthcare operations of your practice.**

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

Print Patient Name _____ DOB_____

Signature: (Parent/Guardian) _____ Date _____

# AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

(Last updated June 2022)

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

**This Authorization allows protected health information to be released by Cornerstone Kids Dentistry to specialists involved in your child's dental care. Including but not limited to an: Orthodontist, Oral Surgeon, Periodontist, or Endodontist.**

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

I affirm that I am the personal representative of the patient, and that I have the authority to authorize the release, use or discloser of the patient's protected health information on his/her behalf. I understand that by signing this form, I am authorizing, on behalf of the patient, the release, use of the patient's protected health information.

**Patient Name**:_____ **DOB**:_____

**Representative Name**:_____ **Relationship to Patient**: _____

**Representative Signature**:_____ **Date**:_____

Cornerstone Kids Dentistry

332 Suffield St  Agawam, MA

# REQUEST FOR DENTAL RECORDS

Child's Name: _____ DOB: _____

**Previous** dental office name::_____ Phone #_____

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

Cornerstone Kids Dentistry
332 Suffield St, Agawam, MA 01001
(413) 786-0077
Please email radiographs to: cornerstonekidsdentistry@gmail.com

Parent's name
(printed):_____

Parent's Signature: _____ Date: _____

Cornerstone Kids Dentistry

332 Suffield St Agawam, MA 01001

## The Importance of Being On Time for Your Appointment

We value your time and strive to provide the best care possible. To ensure that all patients receive the attention they deserve and that our office runs efficiently, we ask that you arrive on time for your scheduled appointment.

Why Timeliness Matters:

- **Respect for Your Time & Others**: Arriving on time helps prevent delays for other patients and allows us to provide the best care for everyone.
- **Full Appointment Time**: Arriving late may result in a shortened visit, which can affect the quality of care you receive.
- **Consideration of Staff Time**: Our team works hard to maintain a timely schedule, and your cooperation helps us stay on track.

Please notify us at least 48hrs in advance if you are unable to make it on time or need to reschedule.

Thank you for your understanding and cooperation.

## OPEN DOOR POLICY

We invite parents to stay with their child during their dental appointment. Due to the limited size of our treatment areas **ONE ADULT** is allowed to stay with the child if they are not ready to be on their own. As your child gets more comfortable with us, we encourage you to allow them to be independent if they wish.

To ensure everyone's safety, other children must remain in the waiting room area (unless they are in a stroller). Children under 12 years of age must be under the supervision of an adult in the waiting area. Our front desk staff are unable to monitor you child(ren) in the waiting area.

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: _____