bloom pediatric dentistry
growing healthy smiles

PATIENT REGISTRATION

TELL US ABOUT YOUR CHILD

Child's Name ______________________________
First Middle Initial Last

Nickname ______________ Gender ________

Child's Birthdate ____/____/____ Child's Age ________

Child's Home Address ______________________________

City, State, Zip ______________________________

How did you choose our office? ______________________________

MOTHER'S INFORMATION

☐ Mother ☐ Stepmother ☐ Guardian ☐ Foster Parent

Name ______________________________

Address ______________________________

City, State, Zip ______________________________

Primary # ______________ Secondary # ______________

Birthdate ______________ SSN ______________

Email Address ______________________________

Marital Status ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced

Do you have legal custody of this child? ☐ Yes ☐ No

FATHER'S INFORMATION

☐ Father ☐ Stepfather ☐ Guardian ☐ Foster Parent

Name ______________________________

Address ______________________________
☐ Same as mother's

City, State, Zip ______________________________

Primary # ______________ Secondary # ______________

Birthdate ______________ SSN ______________

Email Address ______________________________

Marital Status ☐Single ☐Married ☐Separated ☐Widowed ☐Divorced

Do you have legal custody of this child? ☐ Yes ☐ No

INDIVIDUALS OTHER THAN LEGAL GUARDIAN AUTHORIZED TO BRING CHILD AND CONSENT FOR TREATMENT Grandparents, etc.

Name ______________ Relationship ______________

Name ______________ Relationship ______________

Name ______________ Relationship ______________

Signature ______________________________

If treatment involves nitrous oxide, individual must be 18 years or older to bring child.

EMERGENCY CONTACT OTHER THAN LEGAL GUARDIAN

Name ______________________________

Relationship ______________ Phone ______________

PRIMARY DENTAL INSURANCE

Insurance Co. Name ______________________________

Insurance Co. Phone ______________________________

Subscriber Member # ______________________________

Group # ______________________________

Policy Owner's Name ______________________________

Relationship to Patient ______________________________

Policy Owner's Birthdate ____/____/____ SSN ______________

Policy Owner's Employer ______________________________

SECONDARY DENTAL INSURANCE

Insurance Co. Name ______________________________

Insurance Co. Phone ______________________________

Subscriber Member # ______________________________

Group # ______________________________

Policy Owner's Name ______________________________

Relationship to Patient ______________________________

Policy Owner's Birthdate ____/____/____ SSN ______________

Policy Owner's Employer ______________________________

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to the doctors at Bloom Pediatric Dentistry, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental insurance. My part of the expenses will be due today or at the time services are rendered.

____

Signature of Parent/Guardian Print Name Date

bloom pediatric dentistry
growing healthy smiles

PATIENT NAME ____________________ DATE OF BIRTH ____________

Main reason for today's visit: ______________________________

DENTAL HISTORY

How often are the child's teeth brushed? ☐ 1x/day ☐ 2x/day ☐ Every Other Day ☐ Not Regularly
How often are the child's teeth being flossed? ☐ 1x/day ☐ 2x/day ☐ Every Other Day ☐ Not Regularly
Who does the brushing and flossing? ☐ Parent ☐ Child ☐ Half/Half ☐ None
Fluoride Use? ☐ Rx by MD/DMD ☐ in H2O ☐ Toothpaste ☐ Rinse ☐ None
Does your child have any oral habits? ☐ Thumb/Finger ☐ Binky ☐ Mouth Breather ☐ Grinding ☐ None
History of Dental Trauma? If yes, please explain: ______________________________
How would you rate mother's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
How would you rate father's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know
How would you rate your child's sugar consumption? (candy, juice, etc.) ☐ Low ☐ Average ☐ High
When was your child weaned off nursing/bottle? ☐ 6 Months ☐ 12 Months ☐ 24 Months ☐ Still Use ☐ I don't know

MEDICAL HISTORY

Is your child under a physician's care other than his/her PCP? ☐ Yes ☐ No If yes, explain ____________
Has your child ever been hospitalized or had any surgeries? ☐ Yes ☐ No If yes, explain (list dates) ____________
____
Has your child ever had any serious complications from general anesthesia? ☐ Yes ☐ No If yes, explain ____________
Has your child ever had a serious head injury? ☐ Yes ☐ No If yes, explain ____________

DOES YOUR CHILD HAVE ANY ALLERGIES?

☐ None ☐ Aspirin ☐ Penicillin/Amoxicillin ☐ Codeine
☐ Acrylic ☐ Augmentin ☐ Clindamycin ☐ Metal
☐ Latex ☐ Sulfa drugs ☐ Local anesthesia ☐ Zithromax
☐ Other ______________________________

IS YOUR CHILD TAKING ANY MEDICATIONS?

Please list all medications your child is currently taking: ☐ None
____
____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	ADD/ADHD	☐	☐	Chest Pains	☐	☐	Hearing Loss	☐	☐	Lung Disease	☐	☐	Special Diet
☐	☐	AIDS/HIV Positive	☐	☐	Cold Sores/Fever Blisters	☐	☐	Heart Attack/Failure	☐	☐	Malignant Hyperthermia	☐	☐	Speech Therapy
☐	☐	Anaphylaxis	☐	☐	Congenital Heart Disorder	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐	Spina Bifida
☐	☐	Anemia	☐	☐	Diabetes	☐	☐	Heart Pacemaker	☐	☐	Osteoporosis	☐	☐	Stroke
☐	☐	Angina	☐	☐	Drug/Marijuana Use	☐	☐	Heart Trouble/Disease	☐	☐	Pain in Jaw Joints	☐	☐	Tobacco/Vape Use
☐	☐	Arthritis/Gout	☐	☐	Emphysema	☐	☐	Hemophilia	☐	☐	Parathyroid Disease	☐	☐	Thyroid Disease
☐	☐	Artificial Heart Valve	☐	☐	Epilepsy or Seizures	☐	☐	Hepatitis Type ______	☐	☐	Psychiatric Care	☐	☐	Tonsilitis
☐	☐	Asthma	☐	☐	Excessive Bleeding	☐	☐	Herpes	☐	☐	Radiation Treatments	☐	☐	Tuberculosis
☐	☐	Autism	☐	☐	Excessive Thirst	☐	☐	High Blood Pressure	☐	☐	Recent Weight Loss	☐	☐	Tumors or Growths
☐	☐	Blood Disease	☐	☐	Fainting Spells/Dizziness	☐	☐	Hives or Rash	☐	☐	Renal Dialysis	☐	☐	Ulcers
☐	☐	Blood Transfusion	☐	☐	Food Allergies	☐	☐	Intestinal Disease	☐	☐	Rheumatic Fever	☐	☐	Venereal Disease
☐	☐	Breathing Problems	☐	☐	Frequent Cough	☐	☐	Irregular Heartbeat	☐	☐	Rheumatism	☐	☐	Vision Problems
☐	☐	Bruise Easily	☐	☐	Frequent Diarrhea	☐	☐	Kidney Problems	☐	☐	Scarlet Fever	☐	☐	Yellow Jaundice
☐	☐	Cancer	☐	☐	Frequent Headaches	☐	☐	Leukemia	☐	☐	Shingles			
☐	☐	Cerebral Palsy	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Sickle Cell Disease			
☐	☐	Chemotherapy	☐	☐	Hay Fever	☐	☐	Low Blood Pressure	☐	☐	Sinus Trouble			

Has your child ever had any other serious conditions not listed above? Yes No If yes, ____________
If yes to heart murmur, does your child need a pre-medication for dental treatment? Yes No If yes, ____________
Does your child have a genetic disorder? Yes No If yes, ____________
Does your child have a syndrome/disease? Yes No If yes, ____________
Is your daughter: ☐ NA ☐ Pregnant/Trying to get pregnant? Due Date ____________ ☐ Nursing? ☐ Taking oral contraceptives?
Child's physician: Name ____________ Phone ____________ Last appt? ____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform Bloom Pediatric Dentistry of any changes in my child's medical status.

____
Signature of Parent/Guardian (or Patient if 18yo+) Date

bloom pediatric dentistry
growing healthy smiles

PATIENT NAME ____________________

Please initial that you have read and understand each section.

_______ **Financial Policy**

I have received the Bloom Pediatric Dentistry Financial and Insurance Policy that outlines my financial responsibility toward care rendered by the doctors at Bloom Pediatric Dentistry. I understand that the parent or legal guardian who accompanies my child to an appointment will be responsible for payment at the time services are rendered.

_______ **Appointment Cancellation or No-Show Policy**

I take full responsibility for the cancellation/rescheduling of any needed appointments. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, WE REQUIRE AT LEAST A 24 HOUR NOTICE PRIOR TO YOUR APPOINTMENT TIME to avoid a $40 cancellation fee. Many patients are waiting months in advance for appointments, please respect our schedule and our other patients by giving us time to fill your reserved spot with another patient in need of care. Should a patient fail to keep a surgery appointment a $200 fee will be charged if advance notice is not given so that appointment may be given to another child in need of treatment. Should no advance notice of cancellation be given, Bloom Pediatric Dentistry reserves the right to dismiss the patient from the practice after 3 missed or late cancelled appointments.

_______ **Medical/Dental Release Statements**

As the birth/adoptive parent or legal guardian, I give my consent for the doctors of Bloom Pediatric Dentistry to complete a thorough examination on the patient named above including any needed diagnostic radiographs. To the best of my knowledge the information I have provided is accurate and I understand that it will be held in the strictest of confidence and in accordance to all federal and state HIPAA regulations. Further more, I understand that it is my responsibility to inform Bloom Pediatric Dentistry of any future changes to my child's medical history status. As a parent or legal guardian of the previously named patient, I also hereby grant the doctors and staff of Bloom Pediatric Dentistry permission to perform future treatment(s) as deemed appropriate. I understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time services are rendered, unless prior arrangements have been approved.

_______ **Insurance Claim Release & Financial Responsibility Statement**

To precipitate the filing of this and all future dental insurance claims, I do hereby authorize the release of confidential information to my child's dental insurance company. I am aware that Bloom Pediatric Dentistry will be providing an estimate of the insurance coverage prior to initiating any future treatment and that I am legally responsible for any portions not paid by this policy. I understand that additional out-of-pocket expenses may be accrued should estimates provided by my insurance company be inaccurate or should procedures change during the course of the treatment. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 45 days of receiving such treatment.

_______ **Authorization for Direct Payment**

I hereby authorize payment of insurance benefits directly to Bloom Pediatric Dentistry or the dentist that performs treatment on my child. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

_______ **Notice of Privacy Practices, Health Insurance Portability & Accountability Act of 1996**

I have read the form entitled, "Notice of Privacy Practices," and understand its contents concerning the privacy of my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Bloom Pediatric Dentistry from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

I have read and understand the above policies.

____

Signature of Parent/Guardian — Date

Financial Policy and Insurance Information

Methods of Payment

For your convenience we accept cash, check, and all major credit cards (Visa, MasterCard, American Express and Discover). We gladly offer and accept payment plans through CareCredit for dental treatment.

As we strive to be one of Dallas' leading providers for pediatric dental care, we work to assist parents in taking an active role in their child's dental health. Because we value our relationship with you and believe that the best relationships are based upon understanding, we offer these clarifications on methods of payment & insurance reimbursement.

At each visit, we will request a copy of your dental insurance information to allow us to file your claim. Please remember to bring all dental insurance information/insurance card(s) to each appointment. Please contact Bloom Pediatric Dentistry immediately after making any changes to your dental coverage, so we can keep our records current and to provide expeditious reimbursement of your benefits.

If any treatment needs are discovered during your child's exam, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your ESTIMATED out-of-pocket portion for the treatment plan. We will discuss all treatment options and costs before beginning any further treatment. We know that dental insurance can be confusing so feel free to contact us with insurance or payment questions.

Dental Insurance

We are dedicated to providing all our patients with the best treatment available and base all our treatment recommendations on what will be best for your child and not what your insurance company does or doesn't pay. Please note the following in regards to your dental insurance coverage:

1. We must emphasize that as a health care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Most plans routinely pay between 50-75% of the average total fee for a given procedure. This percentage is pre-determined by the plan your employer has purchased.

2. As a courtesy, we will be happy to file for your insurance benefits. Because your dental insurance plan is a contract between you, your employer, and the insurance company, many carriers will not reimburse our office. **In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.**

3. **Any amount not covered by your insurance company is payable at the time services are rendered.** These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. Unfortunately, some of the services that we may recommend for your child may not be covered by your specific dental insurance. Our primary goal is to treat your child using the best possible materials, supplies, medications and environment.

4. We allow a maximum of 45 days for your insurance company to clear account balances. **Any unpaid portions will be due in full, by you, after this period.** If you have not paid your balance within 60 days of the date treatment was rendered, a finance charge of 1.5% will be added to your account each month until paid. Should your insurance company submit payment after this time, we will be glad to reimburse you. This is rare but is important that you recognize that your insurance is a legal contract between you and your insurance company. Our office is not, and cannot be part of that legal contract. Ultimately you are responsible for all charges incurred in our office.

5. Our office does not determine your dental benefits. Your employer chooses your particular policy. If you are unhappy with it's coverage, this should be mentioned to your employer's benefits coordinator. Only your employer can adjust benefits.

Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out-of-pocket portion (estimated patient portion or EPP). Please remember, this is only an estimate based upon generalized information provided by your dental insurance company. An additional billing or possibly a refund may be subsequently required should information provided be inaccurate.

We will always do our best to maximize the insurance benefits that you are eligible to receive and we appreciate your prompt settlement of any charges that may be incurred during the treatment process. We look forward to years of close association with you, as we work together to maintain your child's oral health!