1206 N 1000 W, Suite A
Linton, Indiana 47441
812-847-5101 office | 812-847-5102 fax
www.booepediatricdentistry.com

Patient Name:

DOB:

Chart Number:

PATIENT REGISTRATION DATA

THANK YOU for your expression of confidence by choosing Booe Pediatric Dentistry

Please tell us about your child...

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Gender: ☐ Female ☐ Male Race: _____

Patient Address: _____ Preferred Language: _____

City: _____ Student: ☐ Yes ☐ No School: _____

State: _____ ZIP: _____ Insurance Coverage Information

Who Does Patient Live With? _____ Name of Insurance Co: _____

Name of Employer: _____

How may we contact you for appointment confirmation? Name of Insured: _____

☐ Home Phone: _____ Relationship to Patient: ☐ Parent ☐ Self ☐ Spouse

☐ Cell Phone: _____ Insurance Group ID #: _____

☐ Email: _____ Subscriber's ID #: _____ Birth Date: _____

Please tell us about your child's family...

Guardian Name: _____ Relationship to Patient: _____

Email: _____ Gender: ☐ Female ☐ Male Date of Birth: _____

Address: _____ Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Widowed

City: _____ SSN: _____

State: _____ Zip: _____ Preferred Language: _____

Please provide all information & select one as your primary choice for account correspondence.

☐ Home Phone: _____

☐ Cell Phone: _____

☐ Other Phone: _____

Please provide information about all other parents, legal guardians, and siblings.

☐ Guardian (s) Name: _____

☐ Sibling (s) Name: _____

☐ Other Name: _____

Acknowledgment: Our office requires that a legal guardian is present for all appointments.

Acknowledgment: Full financial responsibility, for all services provided by our office, will be assigned to the legal guardian who brings the patient for the first appointment and who signs our Office Patient Agreement.

Guardian Signature: _____ Date: _____ Time: _____

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PATIENT MEDICAL/DENTAL HISTORY

Patient Name:_____ DOB:_____
City and State of Birth:_____ Gender:_____
Primary Care Physician:_____ Race:_____
Physician Phone:_____ Height:_____ Weight:_____
Date of Last Medical Check-up:_____ Immunizations Up to Date: ☐ Yes ☐ No

DENTAL HISTORY

Previous Dentist:_____ Last Dental Visit:
Has patient had an injury to the mouth, teeth, or jaw? ☐ Yes ☐ No Explain:_____

MEDICAL HISTORY

Does the patient have or had any of the following

Yes / No		Yes / No		Yes / No	
☐	☐ Congenital Heart Defect/Disease	☐	☐ Visual/Hearing Impairment	☐	☐ Eating Disorder
☐	☐ Heart Surgery	☐	☐ Abnormal Bleeding Issues	☐	☐ Born Prematurely
☐	☐ Heart Murmur	☐	☐ Sickle Cell Trait/Disease	☐	☐ Hepatitis A, B, C
☐	☐ High Blood Pressure	☐	☐ Hemophilia/Anemia	☐	☐ Blood Transfusion
☐	☐ Rheumatic Fever	☐	☐ Kidney/Liver Problems	☐	☐ HIV/AIDS
☐	☐ Asthma/Breathing Issues	☐	☐ Diabetes	☐	☐ Chicken Pox
☐	☐ Cerebral Palsy	☐	☐ Failure to Thrive	☐	☐ MRSA
☐	☐ Seizures/Convulsions/Epilepsy	☐	☐ Thyroid/Glandular Problems	☐	☐ Tuberculosis
☐	☐ Autism	☐	☐ Skin Problems/Hives/Cold Sores		
☐	☐ ADD/ADHD	☐	☐ Muscle/Joint/Bone Problems/Limited Mobility		
☐	☐ Learning/Communication Problems	☐	☐ Syndrome (specify):_____		

Is patient currently under the care of a doctor? ☐ Yes ☐ No Explain:_____
Does patient have any allergies? ☐ Yes ☐ No Explain:_____
Is patient taking any medications? ☐ Yes ☐ No Explain:_____

Medication Name:	Dose:	Frequency:

Has patient had surgery or been hospitalized? ☐ Yes ☐ No Explain:_____

I affirm that the information provided above is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office if there is a change in health history of this patient. I authorize the release of this information to additional healthcare providers as is necessary for the dental treatment of this patient. I authorize the dental staff to perform all necessary treatment for this patient. I will not hold the dentist or the dental staff responsible for actions taken or not taken as a result of errors/omissions that I have made in completion of this form. I affirm that my signature represents my agreement to the terms of this agreement.

Guardian Signature:_____ Relationship to Patient:_____ Date:_____

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CONSENT FOR TREATMENT AND PATIENT RESPONSIBILITY AGREEMENT

In each paragraph Booe Pediatric Dentistry will be called "Office". In each paragraph doctors, independent doctors, and associates, will be called "Physicians".

I agree to let the Office, its agents, employees, as well as Physicians give me medical and surgical care. This includes tests, exams, anesthesia, procedures, and drugs.
I agree that neither the Office nor Physicians have made any claims or statements about results or cures.
I agree that my data or body parts including organs, tissue, bone or body fluids may be used for research. The research may or may not relate to my health care. My data or body parts will be carefully treated so that I cannot be identified, except as required by law. I agree that I do not own my body parts after removal and that I have no rights to the research products from these parts.
Infectious Disease Testing: I agree to allow the Office to test for infectious diseases including hepatitis and human immunodeficiency virus (HIV) and that these tests may be ordered by a Physician if one of my care givers is exposed to my blood or body fluid.

Release of Information: I agree to allow any provider that has given me health care in the past to give my medical records to the Office and Physicians and that the Office and Physicians may use my medical records for my health care. I agree that as allowed by law the Office and Physicians may give my medical records to third-party payors, insurance companies, review agencies, employers, welfare departments, and to third-party data service providers including systems like the Indiana Health Information Exchange (IHIE) and the Indiana Network for Patient Care (INPC). This may include records about infectious diseases, drug and alcohol abuse treatment. At anytime, I may change my mind about agreeing to this release of information by giving notice to Office in writing.
I agree that the Office may list my name in its directory.

HIPAA: I agree that I have been offered or given the Hospital's Notice of Privacy Practices.

Pictures: I agree to audio and video recording of my care for Office use only. This includes pictures and recordings used for my medical record, teaching, and quality monitoring and improvement. I will be asked to sign a separate consent if recordings are used for other purposes.

Personal Belongings: I agree that the Office is not liable for loss, theft or damage to my personal belongings. I know the Office wants belongings of value like purses and wallets sent home and that I can keep belongings like dentures, eyeglasses, and hearing aids with me AT MY OWN RISK AND AT MY OWN EXPENSE AND NO ONE AT THE OFFICE CAN CHANGE THIS RISK.
I know the Office has the right to search any of my things on the premises, including purses and wallets, for the safety and welfare of its patients and visitors. I know I can avoid having my things searched by sending them home. I know if the Office decides an item could be a threat to health or safety, the Office may (1) dispose of it, (2) put it in a safe, or (3) give it to law enforcement.

Payment Responsibility: I know that I am responsible for paying for all the care I receive, and if insurance does not cover all the cost, I must pay the rest. I agree that the cost may be based on the Office's chargemaster, and I accept those charges as reasonable. I give the Office and Physicians the right to release my medical records and information and to receive all payments that I am entitled to under insurance policies. I am responsible for knowing what insurance coverage I have and for following all insurance policy rules. I know that if I do not pay what I owe the Office and Physicians, they may send the matter to a collection agency, or attorney and I understand and agree to be responsible for reasonable attorneys' fees, court costs, costs of collection and interest.

I agree that I have read this form carefully and agree that everything in this agreement applies to current and future health care services provided by Office and Physicians.

_____	_____	_____
Signature of Patient/Legal Representative	Date/Time	Relationship of Legal Representative to the Patient

_____	_____	_____	_____
Signature of Guarantor (if other than the Patient/Legal Representative above)	Date/Time	Adult Witness Signature	Date/Time

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OFFICE POLICY

THANK YOU for your expression of confidence by choosing Booe Pediatric Dentistry to provide your child's oral health care. We sincerely appreciate the opportunity to be of service to you. Listed below is important information about our office policies.

Appointment Policies

•Patients are seen by appointment only. Appointments are reserved to ensure that adequate time is allowed to provide your child with the best possible care and outcome. Cancellation of appointments must be made at least twenty-four hours in advance. This will allow us the opportunity to offer this time to another child in need of care. Additional appointments may not be offered if excessive failed and/or cancelled appointments occur.

•A legal parent or guardian must accompany patients for each visit. Parent or guardian should remain in the waiting area during patient's appointment until treatment has been completed and the patient has been dismissed by the doctor. Children who are not accompanied by a legal guardian may not be able to receive the care they have been scheduled for.

•Parent/Guardian is encouraged to accompany their child during the initial exam. For operative treatment, patients will come back independently.

•Eating and drinking are prohibited in patient treatment areas. Smoking is prohibited in Booe Pediatric Dentistry including the properties. Please help us comply with these regulations by refraining from these activities.

Financial Policies

•Payment is due at the time that service is provided. This includes copayments, non-covered services, and balances due after reasonable and customary rates are applied. For your convenience we will accept cash, checks and most credit cards.

•FINANCIAL RESPONSIBILITY: FINAL RESPONSIBILITY FOR PAYMENT RESTS WITH THE PARENT/GUARDIAN WHO SIGNS FOR FINANCIAL RESPONSIBILITY BELOW. Our office will not bill additional persons for services provided regardless of parental agreements.

•STATEMENTS: We will notify you by statement in the event that you have an unpaid balance. The full amount owed will be due within 30 days of your statement date.

•DENTAL INSURANCE: Due to constantly changing insurance regulations, benefits, and deducible levels, we are only able to approximate your insurance benefits. Our office is not a participating provider with all policies. For specific coverage questions please contact your insurance carrier directly.

•DENTAL INSURANCE CLAIMS: We are happy to assist you in filing your dental insurance claims; however, we are only able to offer limited assistance in filing medical insurance claims. Current dental insurance cards must be presented at every visit to ensure accurate and prompt claim filling.

• MEDICAID PLANS: We do accept Indiana Health Care Plans (Medicaid, Hoosier Healthwise). A copy of the member's card or prior authorization must be presented at each visit to ensure billing accuracy. Members, who fail to provide proof of coverage, obtain proper prior authorization, and/or who are not eligible for benefits on the date of service, may be charged for treatment received. Member plans that include a spend-down will be charged based on Medicaid regulations and coverage limitations. Eligible members who choose to receive noncovered treatment will be charged in full for the uncovered services on the date of service. In accordance with Medicaid regulations, eligible members will not be billed for covered/eligible services not paid in full by IHCP.

•PAST DUE ACCOUNTS: Unless previous arrangements have been made with our billing offices, the full balances for services rendered are due within 30 days of your statement date. Balances that remain unpaid after 31 days are considered past due. Past due accounts may be billed an administrative fee and/or referred to a collection agency. In order for us to service your account or to collect any amounts owed, we may contact you by telephone at any telephone number associated with your account, including wireless phones, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messaging, automated dialing services, mail, e-mail, text messaging, and/or person to person contact.

HIPAA & PATIENT PRIVACY: Our office complies with all HIPAA, HITECH, and Patient Privacy regulations. For information regarding the items included in these regulations please ask to review the notice which is available in our office.

AUTHORIZATION FOR GENERAL TREATMENT
ACKNOWLEDGMENT OF RESPONSIBILITY

I affirm that I am a legal guardian or representative for the patient named on this form. I affirm that the information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in my child's medical status, guardian status, and/or residential information. I acknowledge that I have been provided the opportunity to review the Patient Rights and Privacy. I authorize the dental staff to perform all necessary dental treatment my child may need. I authorize the use of any treatment records, x-rays, or photographs for the purpose of teaching, research or scientific publication. I authorize the release of all information necessary to secure benefits otherwise payable to me. I understand that I am responsible for the full balance of the account regardless of my dental benefits unless otherwise prevented by Indiana Healthcare Coverage Plans (Indiana Medicaid) regulations for eligible members. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all the above mentioned terms.

_____ _____
Legal Guardian Printed Name Relationship to Patient

_____ _____
Legal Guardian Signature Date / Time

_____ _____
Witness Date / Time