



Registration Form

409 North Peru
Cicero, IN 46034
317-984-1800

	Date: _____
Tell Us About Your Child	CHILD'S NAME: _____ Date of Birth: _____
	Address: _____ Street City State Zip
	Home Phone: _____ Sex: M / F
	Nickname: _____ School: _____ Grade: _____
Who is Accompanying the Child Today?	Name: _____ Relation to Child: _____
	Do you have legal custody of this child? Yes / No Is the child adopted? Yes / No Is the child in a foster home? Yes / No
	Whom may we thank for referring you? _____
	Other sibling(s) seen by us: _____
Parents	Parent's Marital Status: Married Divorced Separated Widowed Remarried Single
Mother	Name: _____ Home Phone: _____
	Address: _____ Street City State Zip
	Social Security #: _____ Date of Birth: _____
	Employer: _____ Work Phone #: _____
Father	Name: _____ Home Phone: _____
	Address: _____ Street City State Zip
	Social Security #: _____ Date of Birth: _____
	Employer: _____ Work Phone #: _____
Insurance Information	PRIMARY COVERAGE
	<i>Dental Coverage yes / no Orthodontic Coverage yes / no</i>
	Name of Insured: _____ Relation to Child: _____
	Social Security Number of Insured: _____ Date of Birth: _____
	Employer Name: _____ Address: _____ City State Zip
	Insurance Co. Name: _____ Phone # _____
	Insurance Co. Address: _____ Street City State Zip
	Group I.D. #: _____
	SECONDARY COVERAGE
	<i>Dental Coverage Yes / No Orthodontic Coverage Yes / No</i>
	Name of Insured: _____ Relation to Child: _____
	Social Security Number of Insured: _____ Date of Birth: _____
	Employer Name: _____ Address: _____ City State Zip
	Insurance Co. Name: _____ Phone # _____
	Insurance Co. Address: _____ Street City State Zip
Group I.D. #: _____	

Dental History	What is the primary reason for today's visit?			
	Is the child in pain? Yes / No			
	Previous / Present Dentist:		Date of last visit:	Date of last x-rays:
	Why did you leave your previous dentist?			
	Was the previous dental experience positive or negative? Explain			
	Is the primary source of water consumed by the child fluoridated? Yes / No			
	Is (was) the child breastfed or bottle-fed?		until what age?	
	How often does your child brush their teeth? Once or twice daily?			
	How often does your child floss? Zero or once daily?			
	Does your child:			
Y / N suck thumb / finger	Y / N tongue / cheek chew	Y / N clench / grind teeth	Y / N suck / bite lips	
Y / N tongue thrust	Y / N breast feed currently	Y / N mouth breathe	Y / N bottle feed currently	
Y / N use pacifier	Y / N have speech problems or impairment	Y / N bite / chew nails	Y / N trauma to mouth, teeth, or jaw	

Medical History	Child's Physician:		phone:	date last seen:		
	Address:					
	Street		City	State	Zip	
	Is the child currently under the care of a physician? Yes / No please explain?					
	Please list all medications that your child is currently taking:					
	Please list all drug allergies and / or other reactions:					
	Is your child pregnant? Due Date?			Current on immunizations?		
	Has the child had the following:					
	Y / N abnormal bleeding	Y / N rheumatic fever	Y / N asthma, wheezing	Y / N sensory disorder		
	Y / N anemia	Y / N heart disease	Y / N cerebral palsy	Y / N AIDS / HIV +		
Y / N blood transfusions	Y / N heart murmur	Y / N cystic fibrosis	Y / N hospital stays/ operations			
Y / N hemophilia	Y / N congenital heart defect	Y / N epilepsy, seizures, fainting	Y / N cancer/tumors			
Y / N diabetes	Y / N sickle cell, carrier or trait	Y / N tuberculosis (TB)	Y / N radiation or chemotherapy			
Y / N thyroid/endocrine disorder	Y / N headaches, head injury, or	Y / N kidney problems, urinary	Y / N allergies			
Y / N hepatitis/ jaundice	loss of consciousness	tract infections or bed-wetting	Y / N eating disorder			
Y / N liver/stomach/intestinal	Y / N lung problems					
problems						
Any history of mental or physical developmental delays?						
Any learning, behavioral, or communication problems?						
Any history of congenital birth defects?						

Financial Policy	PAYMENT IS DUE AT THE TIME OF SERVICE- The full balance of treatment is due at the time service is rendered. For your convenience we accept cash, check, Care Credit, Master Card, Visa.					
	Assignment of Dental Insurance Benefits- Our office files insurance benefits as a courtesy. Claims unpaid by your insurance co. after 60 days are your responsibility and will be due in full. All deductibles, co-payments, and non-covered fees are due at the time of service. A CURRENT copy of your insurance card must be kept on file to utilize this service. Our office reserves the right to discontinue and / or refuse to file claims.					
	Service Charges- A rebilling fee of \$3.00 may be applied to accounts with balances unpaid within 30 days of the statement date. A \$25.00 fee will apply to all returned checks. Our office reserves the right to pursue any other remedy by law.					
	Delinquent Accounts- Account balances that exceed 90 days may be pursued through third party collections. All reasonable expenses incurred in the collection process will become the account holder's responsibility. Delinquent accounts will incur a charge of 8% interest.					
	How will you be paying?: CASH / CHECK / MASTER CARD / VISA / CARE CREDIT					
CIRCLE ONE						

Authorizations	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. I authorize the dental staff to perform all necessary dental treatment my child may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to Little Smiles Pediatric Dentistry all insurance payments otherwise payable to me. I understand that I am responsible for the full balance of the account regardless of my dental benefits. 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.					
Mother	Signature of Parent or Guardian			Date		

Father	Signature of Parent or Guardian			Date		
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The parent or guardian who accompanies the child is responsible for the patient at the time of service