CHILD'S REGISTRATION AND HISTORY

Date

Child's name | Nickname | Age | Birthdate

Residence address | City | State | Zip

School | Address | Grade

Father's name | Mother's name

Father employed by | How long | Home phone | Bus. phone

Mother employed by | How long | Home phone | Bus. phone

Person financially responsible (if other than parent) | Relationship to child

Address | City | State | Zip | Phone

Father's Social Security number | Driver license no. | State

Mother's Social Security number | Driver license no. | State

Father's birthdate | Mother's birthdate

Credit card name | No. | Expiration date

When dental insurance coverage name of carrier

Secondary insurance coverage, if any

Whom may we thank for referring you

What is child's favorite: sport | toy | hobby | person | fictional character

DENTAL HISTORY

Date of last visit to a dentist ______

For what service ______

	Yes	No
Has child complained about dental problems ______	☐	☐
Any unhappy dental experiences ______	☐	☐
Any injuries to mouth - teeth - head ______	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifer, etc. ______	☐	☐
Any unusual speech habits ______	☐	☐
Any lost teeth ______	☐	☐
Have missing teeth been replaced ______	☐	☐
Orthodontic appliances worn now or ever been ______	☐	☐

	Yes	No
Does your child brush teeth daily ______	☐	☐
Do you assist child with tooth brushing ______	☐	☐
How often ______		
Is dental floss used ______	☐	☐
How often ______		
Are disclosing tablets used ______	☐	☐
Is fluoride taken in any form ______	☐	☐
Do you desire complete dental service for the child ______	☐	☐

Child's attitude to dentistry ______

Summary (for doctor's use) ______

HEALTH HISTORY

Child's physician ______________________ Address ______________________ Phone ______________

Date of last physical examination ______________________ Results ______________________

	Yes	No
Is child under care of physician now ______	☐	☐
Is child receiving any medication or drugs ______	☐	☐
Is there any excessive bleeding when cut ______	☐	☐
Has child ever been hospitalized ______	☐	☐
Has child ever had surgery ______	☐	☐
Is there any allergy to penicillin or other drugs ______	☐	☐
Are there other allergies: food - pollen - animals - dust - other	☐	☐

	Yes	No
Does child have good physical coordination ______	☐	☐
Are there any emotional problems ______	☐	☐

Summary (for doctor's use) ______________________

Has child any history of or difficulty with any of the following:

___ Anemia	___ Chronic sinus	___ Hearing	___ Mastoid	___ Thyroid
___ Asthma	___ Convulsions	___ Heart	___ Measles	___ Tuberculosis
___ Bladder	___ Diabetes	___ Kidney	___ Mononucleosis	___ Venereal disease
___ Cerebral Palsy	___ Epilepsy	___ Liver	___ Mumps	___ Other
___ Chicken pox	___ Fainting	___ Malignancies	___ Rheumatic fever	

Summary: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

____

____

____

____

	Yes	No
May we request release of your child's medical records for our reference ______	☐	☐

This information was discussed with and given by ______________________

Relation to child ______________________

Dr. Howard D. Brooks, D.M.D.
Dr. Barry M. Brooks, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ Individual refused to sign
- ☐ Other (Please Specify)

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____
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General Dental Treatment Consent Form Brooks Dental

54 Woodside Avenue, Winthrop, MA 02152

1. I authorize dental treatment including necessary or advisable examination, radiographs (x-rays), diagnostic aids or local anesthesia.
2. In general terms, dental treatment may include but is not limited to one or a number of the following:
   - Administration of local anesthesia.
   - Cleaning of the teeth and application of topical fluoride.
   - Scaling and root planing with local anesthesia.
   - Application of sealants to the grooves of the teeth.
   - Treatment of diseased or injured teeth with dental restorations. These restorations may either be amalgam (silver) or composite (white).
   - The replacement of missing teeth with a dental prosthesis (crown, partials, etc.).
   - Treatment of diseased or injured oral tissues (hard and/or soft).
   - Treatment of malposed (crooked) teeth and/or developmental abnormalities.
   - Treatment of the canal or pulp chamber that lies in the middle of the tooth and its root also known as "endodontic" therapy or (root canal treatment).

Risks of Dental Procedures in General

Included (but not limited to) are complications resulting from the use of dental instruments, drugs, medicines, analgesics (pain killers), anesthetics and injections. These complications include pain, infection, swelling, bleeding, sensitivity, numbness, and tingling sensations in the lip, tongue, chin, gums, cheeks and teeth, thrombophlebitis (inflammation to a vein), reaction to injections, change in occlusion (biting), muscle cramps and spasms, temporomandibular (jaw) joint difficulty, loosening of teeth or restoration in teeth, injury to other tissues, referred pain to the ear, neck and head, nausea, allergic reactions, itching, bruises, delayed healing, sinus complications, and further surgery. Medication and drugs may cause drowsiness and lack of awareness and coordination (which can be influenced by the use of alcohol or other drugs), thus it is advisable not to operate any vehicle or hazardous device, or work for twenty-four hours or until recovered from their effects.

Changes in Treatment Plan

I understand that during treatment, it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination. Upon my consent, I will give my permission to the dentist to make any/all changes and additions as necessary.

Fillings

I understand that I may experience hot and cold sensitivity, pain or discomfort following routine restorative procedures and that this is usually temporary and should settle without further treatment. If in the event that my condition does not get any better, I understand that I may need further dental treatment, the most common being root canal therapy, resulting in additional costs.

Crown (Caps) and Bridges, **Onlays**

I understand that sometimes it is not possible to match the color of artificial teeth with natural teeth. I further understand that I may be wearing temporary crowns, which my come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge (including shape, fit size, and color) will be before cementation. Once cemented, I understand that any changes in shape, fit, size, or color will incur an additional charge. Upon removal of crowns/veneers, I understand that stumps of teeth may be compromised requiring root canals, periodontal treatment, or extraction that would thus change treatment and incur additional costs.

Alternative Treatment

I understand that I have the right to choose, on the basis of adequate information, from alternate treatment plans that meet professional standards of care.

By signing below, I consent to the general dental treatments and/or proposed treatment.

Patient/Guardian Signature: ______________________________ Date: ______________

Patient Name (Printed): ______________________________

Brooks Dental, P.C.
54 Woodside Avenue
Winthrop, MA 02152
617-846-1811

Office Financial Guidelines:
Thank you for choosing Brooks Dental as your dental health care provider. We are committed to providing you with the highest quality care and service for your dental health needs. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial guidelines. Please read and sign prior to the start of your treatment.

Full payment is due at the time of service.
We accept Cash, Checks, Credit Cards, Care Credit financing (prior credit approval required).

Regarding Insurance:
Co-payment and/or deductible are due at each visit. This may range from 20-50% of your total treatment costs at the time of service. Some insurance companies have a set fee schedule and your out of pocket expense may be higher. All insurance companies have a yearly "maximum covered" amount. It is your responsibility to be aware of that amount and to contact your insurance company if payment is delayed or not paid. The balance is your responsibility whether your insurance pays the estimated amount or not. We cannot submit your claims unless you bring in all insurance information. If your insurance company has not paid your account in full within 30 days, you should be prepared to do so* Please be aware that some or perhaps all of your services provided may be "non-covered" services.

UCR (usual and customary rate):
Our practice is committed to providing the highest quality dental treatment and care for our patients. We believe that patients should have the right to choose their own dentist and dental treatment that best meets their own criteria. Trusting profit motivated insurance companies to select your practitioner, dictate their fees, and control your dental services is against what we believe to be high quality treatment. Therefore we provide fees that are usual and customary for the high quality service that is provided to our patients. It is required that you pay the bill in full regardless of the insurance company's determination of usual and customary rates.

Minors:
The adult accompanying a minor or the parents (or guardian) are responsible for full payment. Before treatment is rendered for unaccompanied minors, prior financial arrangements must be made, Such as an approved credit plan, cash, check, or credit card.

Missed Appointments:
Unless changed at least 24 hours in advance, our guidelines are to charge for missed appointments at a rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Consent to Contact (cell phone calls/texts and emails)
By providing your cell phone number and/or email you consent to receiving such calls or electronic communication at those sites, including but not limited to communication attempts made by automated telephone systems. This consent by Provider and any affiliates, including any and all third party entities hired by Provider for billing, collections, or customer care services.

Thank you for understanding our financial guidelines. Please let us know if you have any questions.
I have read, understand, and agree to the above financial guidelines.

Patient or responsible party:______________________________________ Date:__________________

*Balances outstanding in excess of 90 days are subject to a late payment charge of 1.5% monthly.