Drs. Perlman & Koidin, P.C.

Practice Limited to Pediatric Dentistry and Orthodontics

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PATIENT'S REGISTRATION

Patient's Name (first, middle, last) _____ Nickname _____

Address _____

City _____ State _____ Zip _____ Phone _____

Sex ☐ Male ☐ Female Birthdate _____ Age _____ Social Security Number _____

Have you been to another dental office or clinic? ☐ Y ☐ N Is this an emergency visit? ☐ Y ☐ N

If yes, name of former dentist? _____ Date of last visit _____ Purpose _____

Have any other family members been a patient in this office before? ☐ Y ☐ N If yes, names _____

Legal Guardian's Full Name _____

Address _____

City _____ State _____ Zip _____

Phone: Home _____ Work _____

Social Security Number _____ Birthdate _____

Occupation _____

Employed by _____ Bus. Phone _____

Patient lives with ☐ self ☐ mother ☐ father ☐ group home ☐ other _____

MEDICAL INFORMATION

Physician _____ Address _____ Phone _____

Date of last physical? _____

	Yes	No
Are you in good health?	☐	☐
Are your immunizations up to date?	☐	☐
Are you being treated for any condition presently? If so, explain _____	☐	☐
Are you taking any medications or drugs? If so, explain _____	☐	☐
Have you ever been hospitalized or had surgery? If so, explain _____	☐	☐
Do you have any allergies or reactions to any medications? If so, explain _____	☐	☐

Do you have any allergies to the following?

☐ latex ☐ epinephrine ☐ peanut ☐ penicillin ☐ other _____

Have you ever been diagnosed as having any of the following conditions? Please check yes or no:

Y	N		Y	N		Y	N	
☐	☐	ADD/ADHD	☐	☐	Chronic Headaches	☐	☐	Hyperactivity
☐	☐	AIDS	☐	☐	Chronic Ear Infections	☐	☐	Kidney Disease
☐	☐	Allergies to Medication	☐	☐	Cleft Lip/Palate	☐	☐	Leukemia
☐	☐	Anemia	☐	☐	Convulsions/Seizures	☐	☐	Mental/Emotional Disturbances
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Nutritional Deficiency
☐	☐	Autism	☐	☐	Epilepsy	☐	☐	Oral Ulcers
☐	☐	Bladder Conditions	☐	☐	Eye Problem	☐	☐	Orthopedic Problems
☐	☐	Blood Transfusions	☐	☐	Excessive Bleeding Problem	☐	☐	Premature Birth
☐	☐	Birth Defects	☐	☐	Excessive Gagging	☐	☐	Rheumatic Fever
☐	☐	Bone or Joint Problems	☐	☐	Fainting or Dizziness	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Growth & Development Problems	☐	☐	Sickle Cell Anemia
☐	☐	Bruising Easily	☐	☐	Hearing/Speech Problems	☐	☐	Spina Bifida
☐	☐	Cancer or Malignancies	☐	☐	Heart Problems	☐	☐	Syndrome _____
☐	☐	Cerebral Palsy	☐	☐	Hemophilia	☐	☐	Tuberculosis
☐	☐	Child Abuse	☐	☐	Hepatitis or Liver Disease	☐	☐	Other
☐	☐	Chronic Adenoid/Tonsil Infection	☐	☐	HIV Positive	☐	☐	

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

FOR PATIENTS COVERED BY OTHER DENTAL INSURANCE

PRIMARY CARRIER	SECONDARY CARRIER
Subscriber's Name	Subscriber's Name
Subscriber #	Subscriber #
Group/Policy Number	Group/Policy Number
Employer Name	Employer Name
Insurance Company	Insurance Company
Insurance Mailing Address	Insurance Mailing Address
Insurance Telephone Number	Insurance Telephone Number
Subscriber's Date of Birth	Subscriber's Date of Birth

In order to comply with most insurance companies, we ask that you sign both X's below so that we may keep your signature on file and send the claims to your insurance company.

I have reviewed the following treatment plan.
I authorize release of any information relating to this claim.

X _____
Signed patient or legal guardian

I hereby authorize payment of the dental benefits otherwise payable to me directly to Drs. Perlman & Koidin, P.C.

X _____
Signed insured person

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

In order to release information to anyone besides the patient's legal guardian, please fill out below.

I hereby authorize Drs. Perlman and Koidin, P.C. To release _____ dental records
(patient's name)

To _____
(name of group home, rehabilitation hospital or people we are to release information)

_____
(address)

_____
(city, state, zip code)

This authorization may be revoked at any time in writing except to the extent Drs. Perlman and Koidin, P.C. have acted in reliance of this authorization.

_____ _____
(signature of legal guardian) (date)

FINANCIAL INFORMATION, TERMS AND CONDITIONS

As a condition of treatment by this office, all fees for private accounts must be paid at the time the service is performed unless other arrangements have been made. Payment may be by cash, check, or credit card.

For patients who carry dental insurance, this office will accept assignments of benefits. Any insurance payment not received in 90 days from the date of service will be your responsibility to pay.

In consideration of the professional services rendered to me, I agree to accept responsibility for payment of such services and I agree to pay all costs and reasonable attorney fees incurred by my failure to remit for services rendered. I grant permission to you, or your assignee to telephone me at home or at my work to discuss matters related to this form. I have read the above conditons of treatment and agree to consent:

Signed X _____ Date _____

Medical history reviewed and updated (front and back pages)

_____	_____	_____	_____	_____
(name and date)	(name and date)	(name and date)	(name and date)	(name and date)
_____	_____	_____	_____	_____
(name and date)	(name and date)	(name and date)	(name and date)	(name and date)

Please list below any new allergies or medications including the date of when this occured

_____