903 West Center Street, Suite 130
Rochester, MN 55902

Children's Dental Health Services
WWW.TWENTYTEETH.ORG

P: 507-529-0436
F: 507-529-0435

Registration Form

Patient Information

First Name _____Middle Name _____ Last Name _____

Date of Birth ____/____/____ □ Male □ Female

Race/Ethnicity □ African American □ American Indian □ Asian/Pacific Islander □ Caucasian □ Hispanic □ Other

Does the patient require an interpreter? □ Yes □ No If yes, list language _____

Address _____
Street City State Zip Code

Cell Phone _____ Accepts Text Messages? _____ Home Phone _____

School _____ Grade _____ Teacher _____

Is your child eligible for the school free/reduced lunch program? □ Yes □ No

Parent Guardian Information (If patient is a minor)

First Name _____ Last Name _____

Relationship to patient _____ Email Address_____

□ Yes □ No Does the parent require an interpreter? If yes, list language _____

If different from above
Address _____
Street City State Zip Code

Cell Phone _____ Accepts Text Messages? _____ Home Phone _____

Dental Insurance Information

Please check one □ BluePlus □ MA □ South Country □ U-Care □ Dental Insurance through work
□ Self □ Other _____

Group Number _____ Medicaid ID/PMI Number _____
*Please show insurance card to front desk staff.

Authorization

I authorize Children's Dental Health Services to perform diagnostic procedures and treatment as may be necessary for the patient's proper dental care.

I consent to allow Children's Dental Health Services to use my / my child's / my children's image, voice, and/or words in informational materials such as reports, brochures, videos, etc., and for media interviews. I waive all claims for compensation and release the National Children's Oral Health Foundation from any liability related to such use.
Please print NO if you do not consent to the photo portion of the form:_____

I authorize payment of insurance benefits directly to Children's Dental Health Services. I understand that my dental insurance may pay less or not cover all services rendered. I understand if services are denied or insurance is inactive I could be held responsible for unpaid charges. To my knowledge, all above information is correct and accurate.

Signature _____ Date _____

If this consent is being signed for a minor patient, complete the following:

Parent/Guardian Name _____Relationship to Patient _____

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Consent Form

Patient Name _____

Date of Birth ____/____/____

Please read the following sections carefully

Appointment Policy

Due to the demand for appointments at our clinic, we have developed a policy regarding broken appointments. This policy is intended to assure that valuable appointments are used as effectively as possible. An appointment will be considered broken if the patient 1. Does not show up for an appointment 2. Arrives more than 15 minutes late 3. Cancels the appointment less than 24 hours in advance. Patients with one broken appointment will be placed on a short notice list or walk-in only basis. If you are unable to attend your appointment, please call our office as soon as possible. This will allow us to fill the appointment for someone else who is waiting to be seen.

Notice of Privacy Practice

You have the right to read Children's Dental Health Services' Notice of Privacy Practices before you sign this consent. This notice describes how the patient's medical information may be used and disclosed and how you can get access to this information. A copy of our Notice of Privacy Practice is available to you upon request in our reception area or on our website, www.twentyteeth.org. We recommend you read this Notice carefully and completely before signing this consent. We can change the terms of this notice at any time, and the changes will apply to all information we have about the patient. The new notice will be available upon request and on our website, www.twentyteeth.org.

Right to Revoke

This consent is valid for 12 months effective upon the signing date, however, you have the right to revoke your consent at any time by giving written notice to Children's Dental Health Services. Attn: Program Coordinator · 903 West Center Street, Suite 130 · Rochester, MN 55902. Understand that revocation of this consent will not affect any action we took in reliance on this consent before we received you revocation, and that we may decline to treat the patient or to continue treating the patient if the consent is revoked.

Behavior

For the sake of all individuals, including, but not limited to, the provider and patient, civil behavior showing respect, courtesy and manners must be maintained and observed. Children's Dental Health Services reserves the right to dismiss any individual who is violating this policy from the office.

Communication

I give Children's Dental Health Services permission to send me appointment reminders, communicate insurance and account information, and any other need for communication between provider and patient via text message and/or phone call. In the event your phone number has been disconnected or does not accept voicemail messages, Children's Dental Health Services reserves the right to fill your dental appointment. If your phone number changes please notify us by contacting our front desk staff.

Purpose of Consent

By signing this form, you are giving Children's Dental Health services' consent to use the patient's protected health information to carry out treatment, payment and health care operations. I understand this information will only be used for the dental clinic information limited to our staff, referring dentist, school and public health staff whose work assignments reasonably require access to this data. I have had the opportunity to read the content of this consent form.

Signature _____ Date _____

If this consent is being signed for a minor patient, complete the following:

Parent/Guardian Name _____Relationship to Patient _____

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Health History

Patient Name _____

Date of Birth ____/____/____

Dental History

☐ Yes ☐ No Is this the patient's first dental visit?
If no, list name of dental office and date of last visit _____

☐ Yes ☐ No Current dental problems or concerns?
If yes, please explain _____

☐ Yes ☐ No Does the patient require antibiotics before dental appointments?

☐ Yes ☐ No Has the patient ever had an unusual reaction to a dental anesthetic?

Medical History

Primary Care Physician _____ Clinic _____

☐ Yes ☐ No Is this patient in good health?
If no, please explain _____

☐ Yes ☐ No Does the patient take any medications?
If yes, list _____

☐ Yes ☐ No Does the patient have any allergies?
If yes, list _____

Does the patient have or has had any of the following diseases or health problems?

☐ ADHD/ADD	☐ Heart Disease	☐ Pregnancy
☐ Anemia	☐ Heart Murmur	☐Radiation/Chemotherapy
☐ Asthma	☐ Hepatitis	☐ Rheumatic Fever
☐ Autism	☐ High Blood Pressure	☐ Speech Problems
☐ Cancer or Leukemia	☐ HIV	☐ Tobacco Use
☐ Cystic Fibrosis	☐ Kidney Disease	☐ Tuberculosis
☐ Diabetes	☐ Liver Disease	☐ Other
☐ Epilepsy or Seizures	☐ Pace Maker	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to information Children's Dental Health Services of any changes in medical status.

Signature _____ Date _____

If this consent is being signed for a minor patient, complete the following:

Parent/Guardian Name _____Relationship to Patient _____