Sunshine Pediatric Dentistry
5000 Hollywood Blvd. Suite 1
Hollywood, FL, 33021

Patient Registration & Health History

Patient Name:_____ DOB: _____

Address:_____ Cell Phone: _____ Home Phone: _____

Mothers Name:_____ Fathers Name: _____

Reason for Today's Visit:_____ Last Dental Visit: _____

Name of Insurance: _____ Insurance ID Number: _____

	Circle One	
1: Does the patient have any specific medical condition?		
If yes, please specify _____	YES	NO
2: Does the patient have any physical or mental limitations?		
If yes, please specify _____	YES	NO
3: Has the patient ever had an operation or surgery?		
If yes, please specify _____	YES	NO
4: Has the patient ever been told by a physician that he/she needs to take antibiotics before dental treatment?	YES	NO
5: Does the patient have asthma or breathing problems?	YES	NO
6: Does the patient have a history of seizures?	YES	NO
7: Has the patient tested positive for Hepatitis or HIV?		
If yes, please specify _____	YES	NO
8: Does the patient have any allergies? Medication	YES	NO
Latex	YES	NO
Other	YES	NO
If yes, please specify what and the reaction _____		
_____		
9: Is the patient taking any medication?		
If yes, please list, _____	YES	NO
10: Has the patient ever had any injuries to the teeth, mouth, head or neck?	YES	NO
11: Are there any other conditions or concerns not listed above?		
If yes, please specify _____	YES	NO
12: Does the patient need communication assistance? (Braille, TTY, Sign Language)?	YES	NO
13: Patients primary language? _____		
14: Does the patient have any heart conditions or a heart murmur?	YES	NO

I certify that I have read and understand the above. I acknowledge that the questions above have been answered to my satisfaction. I will not hold my dentist, or other members of his/her staff, responsible for any action they take because of errors or omissions that I may have made in the completion of this form. I have received written information regarding advanced directives. (if applicable)

_____

Signature of Parent/ Guardian Printed Name Date

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5000 Hollywood Blvd. Suite 1
Hollywood, FL, 33021

OFFICE POLICIES

- All cancelations must be made within 48 hours of original appointment.
- We understand that emergencies happen therefore, we have a strict ONE TIME SAME DAY CANCELLATION. If you cancel or reschedule your appointment the same day we will only reschedule for that time only.
- If you cancel or break your appointment on the same day more than once, we will no longer be able to see you in the office.
- All financial responsibilities are between you and your insurance. If a problem or fee surfaces YOU are the responsible party and must pay for the services not covered.
- If you are more than 10 minutes late to your scheduled appointment we may have to reschedule your appointment.

Parent/ Guardian Signature Date

SUNSHINE PEDIATRIC DENTISTRY,

5000 Hollywood Blvd., Hollywood, FL 33021

HIPAA

PATIENT ACKNOLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND CONSENT

I HAVE THE RIGHT TO REVIEW THE NOTICE OF PRIVACY PRACTICES PRIOR TO SIGNING THIS CONSENT. I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND RECEIVE A COPY OF SUNSHINE PEDIATRIC DENTISTRY, NOTICE OF PRIVACY PRACTICES.

With my consent **SUNSHINE PEDIATRIC DENTISTRY, may** use and disclose protected health information about me to carry out treatment, payment and healthcare operations (TPO). Please refer to **SUNSHINE PEDIATRIC DENTISTRY, Notice** of Privacy Practices for a more complete description of such uses and disclosures. **SUNSHINE PEDIATRIC DENTISTRY, reserves** the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Privacy Officer at **SUNSHINE PEDIATRIC DENTISTRY, , 5000 Hollywood Blvd., Hollywood, FL 33021.**

With my consent, **SUNSHINE PEDIATRIC DENTISTRY,** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. **I understand that I have the right to request a restriction on how my information is divulged or mailed, should I wish to exercise this right I understand I need to request it in writing.**

With my consent, **SUNSHINE PEDIATRIC DENTISTRY,** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. **I also understand that I have a right to restrict and limit where my information is sent, should I wish to exercise my right I understand I need to request it in writing.**

I understand that I can request in writing under a separate form, for my medical records to be e-mailed or faxed by SUNSHINE PEDIATRIC DENTISTRY, and that there is potential that this information may reach unintended parties or that the security of these transmissions may be breached in transit. I have the right to request that SUNSHINE PEDIATRIC DENTISTRY, restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

By signing this form, I am consenting to **SUNSHINE PEDIATRIC DENTISTRY, use** and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **SUNSHINE PEDIATRIC DENTISTRY, may** decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Print Name of Patient or Legal Guardian

_____ _____

Patient's Name Date

Good faith attempt to obtain the signature from the patient. Describe the reason why patient did not sign the form:

_____

_____

_____ _____

SIGNATURE OF THE STAFF MEMBER DATE