CHILDREN'S REGISTRATION & HISTORY

Child's Name:_____ Date of Birth:_____

Sex:_____ Preferred Name:_____

Residence Address: _____

School: _____

Responsible Party:_____ Relationship to Child: _____

Social Sec. #_____ Driver's License #_____

Address: _____

Home Phone:_____ Cell Phone: _____

Email: _____ Contact Preference: _____

Insurance Information:

Policy Holder: _____ Employer: _____

Dental Ins. Co. _____ Member ID or SS: _____

Group # _____ Relationship to Policy Holder: _____

Dental History:

Last Dental Visit: _____

For what Service: _____

Complained about dental problems? _____

_____

Any mouth, teeth, head injuries? _____

Does your child brush daily? _____

Do you assist with brushing?_____ How Often? _____

Is dental floss used? _____How Often? _____

Mouth habits-thumb sucking, nail biting, mouth breathing, nursing bottle, pacifier? _____

_____

Any lost teeth? _____

Child's attitude to dentistry:_____ Any missing teeth been replaced?_____

Fluoride taken in any form? _____

Unusual speech habits: _____

Orthodontic appliances worn now or ever? _____

Child's favorite (person, toy,sport,character) _____

Any unhappy dental experiences? _____

Do you desire complete dental services for the child today?_____

Children's Health History

Child's Physician _____ Phone _____

Address _____

Last physical exam _____Results _____

Please Circle & Explain

Is child under care of a physician now ? Yes / No _____

Is child receiving any medication or drugs ? Yes / No _____

Is there any excessive bleeding when cut ? Yes / No _____

Has child ever been hospitalized ? Yes / No _____

Has the child ever has surgery ? Yes / No _____

Is there any allergy to Penicillin or other drugs ? Yes / No _____

Are there any other allergies:food,pollen,animal,dust,other ? Yes / No _____

Does child have good physical coordination ? Yes / No _____

Are there any emotional problems ? Yes / No _____

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

Anemia _____ Chronic _____ Sinus _____Hearing_____

Mastoid _____Thyroid _____Convulsions _____ Asthma _____

Heart _____ Measles _____ Tuberculosis _____Bladder _____

Diabetes _____ Kidney _____ Mononucleosis _____ Epilepsy _____

Liver _____ Chicken Pox _____ Venereal Disease _____ Mumps _____

Fainting _____ Malignancies _____ Cerebral Palsy _____ Rheumatic fever _____

Other _____

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

_____

_____

May we request your child's medical records? _____

This information was discussed & given by _____

Relation to child _____

CLINICAL PROCEDURES CONSENT

Patient Name: _____ **Date of Birth**: _____

I hereby consent to the dental and surgical care and treatment, as may be deemed necessary or advisable in the judgement of my dentist or other provider. This may include, but is not limited to diagnostic testing, surgical treatment, procedures, or services rendered during my visit at L'Anse Family Dental LLC.

To ensure that you understand all aspects of your visit, you are encouraged to ask any questions or clarify any procedures prior to them being performed. Our dental providers will answer any questions and discuss any procedures, concerns, and goals with you regarding the following:

- Benefits of the proposed treatment.
- The way the treatment or procedure is to be performed.
- Alternative treatment options.
- Probable consequences of not receiving the treatment.
- The right to withdraw informed consent at any time, in writing.
- Risk and side effects involved with the procedure.
- Potential for additional incurred charges.

I acknowledge that some treatment will require multiple visits with one or more methods that may change throughout the course of the treatment and each office visit and procedure will be billed accordingly. **_____(Initials)**

If a complication after treatment would arise, there may be a charge for the management that will be submitted to your insurance company. I recognize that dental work is not an exact science and acknowledge that I am responsible for payment in full for the charges incurred for the procedures regardless of the coverage provided by my insurance carrier. If I am concerned about the cost associated with treatment, it is my responsibility to request a treatment estimate prior to starting treatment**.** **_____(Initials)**

I have read the consent form in its entirety. I understand the risks associated with the procedures that may occur during my visits at L'Anse Family Dental. I do not impose any limitations on L'Anse Family Dental and its staff. I understand that I should discuss any questions or concerns with my dental provider to any treatment and therefore, with my signature, agree to have any necessary treatment performed.

_____ _____

Patient signature/Date **Witness signature/Date**

The undersigned hereby provides consent as the parent or guardian of the above referenced minor patient.

_____ _____

Parent or guardian signature/Date ***Relationship to Patient***

Acknowledgment of Receipt of Privacy Practices

I acknowledge that I received a copy of L'Anse Family Dental, PLLC Notice of Privacy Practices

Patient Name_____

Patient Signature_____

Date_____

Agreement to Minor Child's photographic image being taken and displayed

Patient Name_____ Date of Birth_____

Guardian Name_____ Date of Birth _____

I agree the L'Anse Family Dental may take and display my minor child's photographic image for the purpose of the 'No Cavity Club'.

I can withdraw my consent of the use of my child's image by calling 906 524-6420

Guardian Signature_____ Date_____

APPOINTMENT POLICY

L'Anse Family Dental requires at least 24 hours' notice of cancellation prior to the scheduled appointment time. If you fail to give 24 hours' notice of cancellation OR do not show for your scheduled appointment, it will count as a MISSED APPOINTMENT.

Two (2) MISSED APPOINTMENT occurrences will result in dismissal from our practice.

Additionally, we request that you arrive for your appointment on time. If you are late, your appointment may need to be rescheduled.

_____ _____

(Patient's Name) (Date)