

## Child Registration Form

This form is for patients under the age of 18 years  
and must be completed and signed by a person who is a legal guardian of the patient.

### Patient Information

Date \_\_\_\_\_

Patient's name \_\_\_\_\_

Last

First

Middle

Address \_\_\_\_\_

Street

City

Zip

Home phone \_\_\_\_\_ Cell \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

**Email** \_\_\_\_\_ Patient lives with \_\_\_\_\_

School \_\_\_\_\_ Hobbies or interests \_\_\_\_\_

Siblings:

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Last (if different)

First

Last (if different)

First

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Last (if different)

First

Last (if different)

First

How did you hear about our office? \_\_\_\_\_

Are you on **Facebook**? Yes No

We are!



[www.facebook.com/kennet.orthodontics](http://www.facebook.com/kennet.orthodontics)

### Responsible Party Information

Name \_\_\_\_\_

Last

First

Middle

Relationship to patient \_\_\_\_\_ Legal guardian of patient? Yes / No

Address \_\_\_\_\_

Street

City

Zip

Home phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

**E-mail** \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ No. years employed \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Last

First

Middle

Address \_\_\_\_\_

Street

City

Zip

Relationship to patient \_\_\_\_\_ Legal guardian of patient? Yes / No

Home phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

**E-mail** \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_ No. years employed \_\_\_\_\_

### Emergency Contact Information

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_

Street

City

Zip

Home phone \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

# Dental Insurance Information

Policyholder's Name \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance company name: \_\_\_\_\_  
Insurance company address \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Contract/ SS # \_\_\_\_\_

## Additional Dental Insurance:

Policyholder's Name \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Insurance company name: \_\_\_\_\_  
Insurance company address \_\_\_\_\_  
Insurance Phone # \_\_\_\_\_ Group # \_\_\_\_\_ Contract/ SS # \_\_\_\_\_

# Dental History

Dentist Name \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address/City: \_\_\_\_\_ Phone # \_\_\_\_\_

**I authorize Kennet Orthodontics to share clinical information with other dental professionals to ensure optimal dental health and best possible results.** \_\_\_\_\_

Signature

What concerns you most about patient's teeth? \_\_\_\_\_

Please circle Yes or No (If Yes, please fill in details)

- |  |     |    |       |
|--|-----|----|-------|
| Is patient presently in any dental pain?                     | Yes | No | _____ |
| Have there been any injuries to face, mouth or teeth?        | Yes | No | _____ |
| Does patient have any thumb-sucking or tongue habits?        | Yes | No | _____ |
| Has patient ever seen an orthodontist? If yes, who and when? | Yes | No | _____ |
| Has anyone in your family received orthodontic treatment?    | Yes | No | _____ |
| Does the patient experience jaw clicking or popping?         | Yes | No | _____ |
| Does the patient clench their teeth during the day?          | Yes | No | _____ |
| Does patient have tension headaches?                         | Yes | No | _____ |
| Has patient ever experienced chronic ringing in their ears?  | Yes | No | _____ |
| Does patient have a fear of the dentist?                     | Yes | No | _____ |

# Medical History

Physician Name \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Please circle Yes or NO (If Yes, please fill in any details)

**Is patient allergic to Latex? Yes No** \_\_\_\_\_

Is patient taking any medication? Yes No \_\_\_\_\_

Medication taken for: \_\_\_\_\_

Is patient allergic to any medication? Yes No \_\_\_\_\_

Is there a history of a major illness? Yes No \_\_\_\_\_

Is there a history of major operations? Yes No \_\_\_\_\_

Is there a history of a serious accident? Yes No \_\_\_\_\_

Is patient pregnant? Yes No \_\_\_\_\_

If you answered yes to any question, please give details here \_\_\_\_\_

**Please continue on next page →**

Circle Yes or No if patient has had or currently has any of the following medical conditions:

Nervous Disorders	Yes	No	Arthritis	Yes	No	Heart Problems	Yes	No
Asthma / Hay fever	Yes	No	Heart Murmur	Yes	No	Prolonged Bleeding	Yes	No
Bone Disorders	Yes	No	Hepatitis/Liver Problems	Yes	No	Radiation/Chemotherapy	Yes	No
Herpes	Yes	No	Rheumatic Fever	Yes	No	Diabetes	Yes	No
Tuberculosis	Yes	No	Dizziness	Yes	No	HIV/ Aids	Yes	No
Tumor or cancer	Yes	No	Epilepsy	Yes	No	Kidney Problems	Yes	No
Pneumonia	Yes	No	High Blood Pressure	Yes	No	Heart Defect	Yes	No
Gastrointestinal Disorders	Yes	No				Abnormal bleeding/Hemophilia	Yes	No

If you answered yes to any question, please give details here: \_\_\_\_\_

Are there any medical or mental conditions not mentioned above? Yes No

Please explain: \_\_\_\_\_

Does patient have learning disabilities or need assistance with instructions? Yes No

Please explain: \_\_\_\_\_

**I have truthfully answered all the questions and agree to inform this office of any changes in my medical or dental history. I authorize Kennet Orthodontics to take any necessary x-rays. In addition, I authorize Dr. Kennet to perform a complete orthodontic evaluation.**

**Parent or Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## HIPAA

Effective April 14, 2003 the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review of entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

## Patient Acknowledgment/Consent

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

**Signature:** I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices. I understand that by signing this Consent Form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Parent or Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_