Kennet Orthodontics

www.kennetortho.com

Beautiful Smile…
Lasting Impression

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 State Zip

Birthdate _____/_____/_____ 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? _____

Parent / Guardian Information (All parties who are legally responsible for minor)

Information for both Parents/Guardians must be completed in full in order for appointment to proceed.

Parent / Guardian #1: _____
Last First Middle

Relationship to patient_____ Legal guardian of patient? Yes / No

Address _____
Street City State Zip

Home phone _____Cell _____Work _____

E-mail_____ Birth date ____/____/_____ Social Security #_____

Employer _____ Occupation _____ No. years employed _____

Parent / Guardian #2: _____
Last First Middle

Relationship to patient_____ Legal guardian of patient? Yes / No

Address _____
Street City State Zip

Home phone _____Cell _____Work _____

E-mail_____ Birth date ____/____/_____ Social Security #_____

Employer _____ Occupation _____ No. years employed _____

Emergency Contact Information

Name of nearest relative not living with you_____

Complete address_____
Street City State Zip

Home phone _____Cell _____Work _____

Please continue on next page ➔

19991 Hall Road, Suite 101 ▪ Macomb, Michigan 48044 ▪ Phone: 586-416-4455 ▪ Fax: 586-416-4422

Dental Insurance

Primary

Policyholder's Name_____ Birthdate: _____/_____/_____

Insurance company name: _____ Insurance Phone #_____

Policyholder ID # / SSN #_____ Group # _____

Secondary:

Policyholder's Name_____ Birthdate: _____/_____/_____

Insurance company name: _____ Insurance Phone #_____

Policyholder ID # / SSN #_____ Group # _____

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 the best possible results. _____

Signature

What concerns you most about the 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	_____
Are you aware of patient's jaw clicking or popping?	Yes	No	_____
Are you aware of patient clenching your teeth during the day?	Yes	No	_____
Does patient have tension headaches?	Yes	No	_____
Has patient ever experienced chronic ringing in your 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	List_____
			_____
Allergies 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	_____

Please continue on next page ➔

Circle Yes or No if patient currently has or has a history 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	Pneumonia	Yes	No	Herpes	Yes	No
Rheumatic Fever	Yes	No	Diabetes	Yes	No	Tuberculosis	Yes	No
Dizziness	Yes	No	HIV/ Aids	Yes	No	Epilepsy	Yes	No
Tumor or cancer	Yes	No	Kidney Problems	Yes	No	Heart Defect	Yes	No
Radiation/Chemotherapy	Yes	No	High Blood Pressure	Yes	No	Gastrointestinal Disorders	Yes	No
Abnormal bleeding/ Hemophelia	Yes	No	Hepatitis/ Liver Disorders	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 _____

_____

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

_____

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 / Guardian 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.

Parent / Guardian Acknowledgment/Consent

Purpose of Consent: By signing this form, you will consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and health care operations. Any electronic communication may not be secure.

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 the patient's protected health information to carry out treatment, payment activities and health care operations.

Parent / Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____