*WELCOME*

*WE ARE SO PLEASED YOU HAVE CHOSEN*

*TO BE A PART OF OUR PRACTICE.*

*IN ORDER FOR YOU TO ENJOY YOUR*

*VISIT WE HAVE PROVIDED INFORMATION TO*

*HELP GUIDE YOU WITH OUR POLICIES.*

*PLEASE READ CAREFULLY AND IF YOU HAVE*

*ANY QUESTIONS PLEASE ASK.*

*DR. GENE KOURI, DDS, MSD*
*DR. MORNA STAFFEL, DDS*
*&*
*STAFF*

# CHILDS REGISTRATION AND HISTORY

_____ Date

**ALL BLANKS MUST BE COMPLETED**

**PATIENT INFORMATION**

Child's Name _____ DOB _____ M __ F ___ Medicaid # _____

Address _____ Apt# _____

City _____ State _____ Zip _____ Phone (____) _____

Has Child seen a dentist before? _____ If yes: when, where and were there any unfavorable experiences?

_____

How did you find out about us? _____

What is your preferred way to be contacted: Phone _____ Text Message _____ Email _____

Email address: _____

**FAMILY INFORMATION**

Mother's Name _____ DOB _____ Marital Status M / S

Home Address _____

City _____ State _____ Zip _____ Phone (____) _____ Cell/Pager (____) _____

Social Security Number _____ Employer _____

Employer's Address _____

City _____ State _____ Zip _____ Bus Phone (____) _____

DL # _____

Father's Name _____ DOB _____ Marital Status M / S

Home Address _____

City _____ State _____ Zip _____ Phone (____) _____ Cell/Pager (____) _____

Social Security Number _____ Employer _____

Employer's Address _____

City _____ State _____ Zip _____ Bus Phone (____) _____

DL # _____

**INSURANCE INFORMATION INFORMATION**

Insurance Company Name _____

Claim Mailing Address _____

City _____ State _____ Zip _____ Bus Phone (____) _____

Employee ID# _____ Group # _____

Insurance Company Name _____

Claim Mailing Address _____

City _____ State _____ Zip _____ Bus Phone (____) _____

Employee ID# _____ Group # _____

## DENTAL HISTORY

Date of last visit to dentist _____

For what service _____

_____

| | YES | NO |
|---|---|---|
| Has child complained about dental problems _____ | ☐ | ☐ |
| Any unhappy dental experiences _____ | ☐ | ☐ |
| Any injuries to mouth - teeth - head _____ | ☐ | ☐ |
| Any mouth habit - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____ | ☐ | ☐ |
| Any unusual speech habits _____ | ☐ | ☐ |

| | | |
|---|---|---|
| Any lost teeth _____ | ☐ | ☐ |
| Have missing teeth been replaced _____ | ☐ | ☐ |
| Othodontic appliances worn now or ever been _____ | ☐ | ☐ |
| Does your child brush teeth daily _____ | ☐ | ☐ |
| Do you assist child with tooth brushing _____ | ☐ | ☐ |

How often _____

Child's attitute to dentistry _____

_____

_____

| | | |
|---|---|---|
| Do you desire complete dental service for the child _____ | ☐ | ☐ |

explain _____

## HEALTH HISTORY

Child's Physician _____

Phone _____

| | YES | NO |
|---|---|---|
| Is child under care of physician now _____ | ☐ | ☐ |
| Is child receiving any medication or drugs _____ | ☐ | ☐ |
| Is there any excessive bleeding when cut _____ | ☐ | ☐ |
| Has child ever been hospitalized _____ | ☐ | ☐ |

| | | |
|---|---|---|
| Has child ever had surgery _____ | ☐ | ☐ |
| Is there any allergy to penicillin or other drugs _____ | ☐ | ☐ |
| Are there other allergies: food-pollen-animals-dust-other _____ | ☐ | ☐ |
| Are there emotional problems _____ | ☐ | ☐ |
| Childhood diseases _____ | ☐ | ☐ |

## HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING: PLEASE "X" EACH BOX IF THE ANSWER IS "YES." LEAVE BLANK IF "NO."

1. ☐ HEART PROBLEMS
2. ☐ HIGH BLOOD PRESSURE
3. ☐ LOW BLOOD PRESSURE
4. ☐ CIRCULATORY PROBLEMS
5. ☐ RHEUMATIC FEVER
6. ☐ HEPATITIS
7. ☐ DIABETES
8. ☐ RADIATION TREATMENTS
9. ☐ EPILEPSY
10. ☐ KIDNEY PROBLEMS
11. ☐ NERVOUS PROBLEMS
12. ☐ TUBERCULOSIS
13. ☐ EXCESSIVE BLEEDING
14. ☐ CEREBRAL PALSY
15. ☐ SCARLET FEVER
16. ☐ MALIGNANCIES
17. ☐ CHRONIC SINUS
18. ☐ CHRONIC EAR PROBLEMS
19. ☐ ANEMIA
20. ☐ ARTHRITIS
21. ☐ ADENOIDS REMOVED
22. ☐ TONSILS REMOVED
23. ☐ ASTHMA
24. ☐ VENERIAL DISEASE/HERPES
25. ☐ AIDS
26. ☐ BLOOD TRANSFUSION

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

_____

_____

_____

_____

| | YES | NO |
|---|---|---|
| May we request release of your child's medical records for our reference _____ | ☐ | ☐ |

Emergency Information: Name of Nearest Relative _____

Address _____ Phone _____

I understand that cancellations require 24 hrs. notice, or a charge of $25 will apply.
I consent to whatever Dental Procedures and anesthetics are necessary for the treatment of the above named patient.
I also agree to assume full Financial Responsibility for all treatment rendered. It is understood and agreed by me that I will pay all Attorney Fees and other costs necessary for the collection of any amount not paid by me when due.

★ **It is understood that the Parent accompanying the patient is responsible for payment at the time of treatment.** ★★ _____ (Initial)

Signature (Must be signed before treatment rendered) _____

Updates (date & initial) _____ _____ _____ _____ _____

EUGENE KOURI, D.D.S., M.S.D.
MORNA STAFFEL, D.D.S.

# PATIENT CONSENT TO PROVIDE HEALTH AND BILLLING INFORMATION TO DESIGNATED PERSONS

I understand that as part of the provision of healthcare services, my physician creates and maintains health records, billing records and other information describing among other things, my drug history, my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment. These records are referred to in this document as "Protected Healthcare Information" also referred to as "PHI". I further understand that this assists my physician in carrying out his treatment, payment and healthcare operations.

By signing this form, I consent to the use and disclosure of protected healthcare information about me to certain persons designated by me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent.

I authorize the person (s) listed below to have access to the following (check applicable categories for each person listed):

1._____ _____
Name Relationship to patient

_____
Address

_____
Phone Number (s)

This person may:

( ) pick up test results, medical records, letters

( ) pick up any written prescriptions

( ) receive billing and account information

( ) pick up medication samples

( ) All of the above

2. _____ _____
Name Relationship to Patient

_____
Address

_____
Phone Number(s)

This person may;

( ) pick up test results, medical records, letters ( ) pick up any written prescriptions

( ) receive billing and account information ( ) pick up medication samples

( ) All of the above

3. _____ _____
Name Relationship to Patient

_____
Address

_____
Phone Number (s)

This person may pick up:

( ) pick up test results, medical records, letters ( ) pick up any written prescriptions

( ) receive billing and account information ( ) pick up medication samples

( ) All of the Above

**A fax or photocopy of this consent is as valid as the original**

_____ _____
**NAME (PRINT)** **DATE**

_____ _____
**SIGNATURE** (of Guardian, if Minor) **SOCIAL SECURITY NUMBER**

_____ _____
**WITNESS** (Optional) **DATE**