



Pediatric Dentistry West

Dr. John Bozic | Dr. Zach Bozic



New Patient Registration

Patient Name: _____

Last

First

Middle

Address: _____

Street # & Name

City

State

Zip Code

Home# : (____) ____ - ____ Date of Birth: ____/____/____ Age: ____ Sex: M F

Name of Siblings: _____

Parent/Guardian Information

Name: _____ Relationship to child: _____

Gender: M F DOB: ____/____/____ Social Security Number: ____-____-____

Marital Status: Single Married Divorced Separated Domestic Partnership

Address (if different from above): _____

Email Address: _____

Home# : (____) ____ - ____ Cell# : (____) ____ - ____ Work# : (____) ____ - ____

Name: _____ Relationship to child: _____

Gender: M F DOB: ____/____/____ Social Security Number: ____-____-____

Marital Status: Single Married Divorced Separated Domestic Partnership

Address (if different from above): _____

Email Address: _____

Home# : (____) ____ - ____ Cell# : (____) ____ - ____ Work# : (____) ____ - ____

Insurance Information

Primary Dental Ins. Company Name: _____

Policy Holder: _____ Policy Holder's DOB: ____/____/____

Employer: _____ ID#: _____ Group#: _____

Secondary Dental Ins. Company Name: _____

Policy Holder: _____ Policy Holder's DOB: ____/____/____

Employer: _____ ID#: _____ Group#: _____

I grant Dr. John A. Bozic, DDS and Dr. Zachary D. Bozic, DDS, MSD permission to provide dental examination and treatment. I further agree to be responsible for the cost of this dental care. I understand that I am financially responsible for all treatment incurred by my child, including any amounts not covered by my insurance company, interest on unpaid amounts, and reasonable cost of collection efforts should my account become delinquent.

X _____
Signature Date





Child's Name: _____ Date: _____

MEDICAL HISTORY

Please Mark "YES" if your child has a history of the following For each "YES", please provide details in the space provided below.

Y N

Seizures/Convulsions/Dizziness/Loss of Consciousness

Cerebral Palsy/Developmental Delay

Social/Cognitive/Mental Delay

Autism/Asperger's Syndrome

ADHD/ADD

Born with/Current Heart Issues

Anemia/Excessive Bleeding/Blood Problems

Asthma/Bronchitis/Pneumonia/Shortness of Breath

Kidney/Bladder Problems

Cancer/Tumor/Leukemia

Hearing Problems/Deaf

Malignant Hyperthermia

Vitamin B-12 Deficiency

Operations/Surgeries

Gets along with playmates?

If you answered "YES", please elaborate here:



Current Medications: _____

ALLERGIES

Y N

Latex

Seasonal

Y N

Food _____

Medication _____ Reaction _____

Does your child have any other major medical problems we should know about? Please elaborate.



Child's name: _____ Date: _____

DENTAL HISTORY

Y N

Is today your child's first dental visit

What is the primary purpose of today's visit? _____

If no, who was the child's previous dentist? _____

Date of last visit: ____/____/____ Purpose of last visit: _____

Do you believe your child will react well to today's treatment?

What do you think we can do to make your child's visit a positive experience? _____

At the present time, does your child (check all that apply):

Y N Y N

Use a pacifier

Tongue thrust

Use a sippy cup

Have bleeding gums

Suck thumb/fingers

Lip or cheek biting

Bite nails/chew on objects

Grind teeth

Have any loose teeth

Mouth breathe

Have a broken filling

Bottle feed

Take anything to drink
to bed (besides water)

Have braces

Dental Routine (check all that apply):

Fluoridated toothpaste	Brushing alone	___ times daily
Fluoridated mouthwash	Brushing by parent	___ times daily
Drink fluoridated water	Dental floss	___ times weekly

Consent

Fluoride (essential for promoting health of teeth and preventing cavities):

X-rays (for diagnosing tooth decay and growth development):

I give consent for any and all employees to take and/or display photographs of my child on the PDW website, social media, and/or in our office.

Who referred you to our office? _____





Office Policies

We are committed to providing you with high quality dentistry and our fees reflect our professional commitment to excellence.

For the convenience of our patients, we accept the following:

Personal Checks and Cash – Are always welcome.

Bankcards – We accept Visa, Discover, American Express, and Master Card for credit or debit.

Insurance – Co-payments will be estimated and due at the time of service. As a courtesy to our patients, we will submit all necessary information and bill your insurance company once. You are responsible for your bill regardless of insurance coverage. Please take the time to understand your policy.

Emergencies – First time patients will be seen on a cash basis unless insurance coverage can be verified.

NSF Checks – There is a \$30 fee for all returned checks.

Cancellations – We require 24 hour notice if you are unable to make your appointment. Failure to contact us, or to arrive for scheduled appointments, may result in a \$25 fee or dismissal from our practice.

Collections – Any fees incurred as a result of turning a delinquent account to collections will be the responsibility of the account holder.

I have reviewed and understand the above policies.

Signature_____ **Date**_____



Pediatric Dentistry West

Dr. John Bozic | Dr. Zach Bozic



HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

The Consent was signed by: _____

Printed Name of Patient/Guardian or Representative

Signature

Date

Relationship to Patient (if other than patient): _____