New Patient Registration Form

Fòm anrejistreman pou nouvo pasyan

Today's Date: _____ Patient (Child's) Name: _____
Dat jodi a *Non pasyan (timoun nan)*

Date of Birth: _____ Age: _____ Gender (circle): Male Female
Dat nesans *Laj* *Sèks (mete yon sèk nan youn):* *Gason* *Fi*

School Name: _____ Reason for Visit: _____
Non lekòl la *Rezon vizit la*

Child's Pediatrician: _____ Phone: _____
Pedyat timoun nan *Telefòn*

Your Name: _____ Date of Birth: _____
Non w *Dat nesans*

Your relationship to patient: _____
Sa w ye pou pasyan an

Street Address: _____ City: _____ State: _____ Zip: _____
Adrès *Vil* *Eta* *Kòd postal*

Home Phone: _____ Cell Phone: _____ Work Phone: _____
Nimewo telefòn nan kay la *Telefòn selilè* *Telefòn travay*

Email: _____ Driver's License #: _____
Imèl *Nimewo lisans chofè*

Spouse Name: _____ Date of Birth: _____
Non konjwen w *Dat nesans*

Preferred contact method? (circle as applicable) E-mail Text Home Phone Cell Phone Work Phone
Metòd ou prefere pou yo kontakte w? *Imèl* *Tèks* *Telefòn lakay* *Telefòn selilè* *Telefòn travay*

Emergency contact (other than you): Name: _____
Moun pou kontakte nan yon kadijans (apade ou menm): Non

Relationship to Patient: _____ Phone: _____
Sa moun nan ye pou pasyan an *Telefòn*

Besides you, provide 2 alternate adults (over age 18) who are <u>authorized</u> to bring your child to the dentist?
Apade ou menm, bay non 2 lòt adilt (ki gen plis pase 18 an) ki <u>otorize</u> pou mennen pitit ou a kay dantis la?

1) Name: _____ Relationship to Patient: _____
Non *Sa l ye pou pasyan an*

Street Address: _____ City: _____ State: _____ Zip: _____
Adrès *Vil* *Eta* *Kòd postal*

Home Phone: _____ Cell Phone: _____
Nimewo telefòn nan kay la *Telefòn selilè*

Driver's License #: _____ Date of Birth: _____
Nimewo lisans chofè *Dat nesans*

2) Name**:** _____ Relationship to Patient: _____
Non *Sa l ye pou pasyan an*

Street Address: _____ City: _____ State:_____ Zip: _____
Adrès *Vil* *Eta* *Kòd postal*

Home Phone: _____ Cell Phone: _____
Nimewo telefòn nan kay la *Telefòn selilè*

Driver's License #: _____ Date of Birth: _____
Nimewo lisans chofè *Dat nesans*

Referral Source: How did you hear about us? Please be as specific as possible.
Sous rekòmandasyon: Ki jan w te tande pale de nou? Tanpri presize otank sa posib.

- ❑ Pediatrician (specify below) *Pedyat (presize anba a)*
- ❑ Magazine (specify below) *Jounal (presize anba a)*
- ❑ Friend (specify below) *Zanmi (presize anba a)*
- ❑ Relative (specify below) *Fanmi (presize anba a)*
- ❑ Driving by *Pase nan zòn nan*
- ❑ Sports and activities *Spò ak aktivite*
- ❑ Autism Notebook *Kaye otis*
- ❑ Google
- ❑ Zocdoc
- ❑ Facebook
- ❑ School (specify below) *Lekòl (presize anba a)*
- ❑ Insurance (specify below) *Asirans (presize anba a)*
- ❑ Other (specify below) *Lòt (presize anba a)*

Referral/Source Name: _____
Non sous/rekòmandasyon

Patient Medical and Dental History

Antesedan medikal ak dantè pasyan an

Does your child have a history of **ANY** of the following medical conditions below? Please check **ALL** that apply.
*Èske pitit ou a te janm genyen **NENPÒT** nan pwoblèm medikal ki pral site anba a? Tanpri tyeke **TOUT** sa ki aplikab.*

- ❑ Heart Disease — *Maladi kè*
- ❑ Organ Transplant — *Grèf ògàn*
- ❑ HIV/AIDS — *VIH/SIDA*
- ❑ Sickle Cell Disease — *Maladi anemi falsifòm*
- ❑ Rheumatic Fever — *Rimatis atikilè egi*
- ❑ Endocarditis — *Endokadis*
- ❑ Diabetes (Type I or II) — *Dyabèt (Tip I oswa II)*
- ❑ Abnormal Bleeding/ Hemophilia/Thalassemia — *Sèyman anòmal/emofili/talasemi*
- ❑ History of Cardiac Surgery — *Antesedan operasyon kadyak*
- ❑ History of Blood Transfusions/Dialysis — *Antesedan transfizyon san/dyaliz*
- ❑ Bone Marrow Transplant — *Grèf mwèl ose*
- ❑ History of Cancer/Tumors — *Antesedan kansè/timè*
- ❑ Cerebral Palsy — *Enfimite motris serebral*
- ❑ Tuberculosis — *Tibèkiloz*
- ❑ Seizures/Epilepsy — *Kriz/malkadi*
- ❑ Hepatitis Type A/B/C — *Epatit tip A/B/C*
- ❑ Cystic Fibrosis — *Mikovisidoz*
- ❑ Liver/Kidney Disease — *Maladi fwa/ren*
- ❑ Sleep Apnea — *Apne somèy*

The conditions in this box <u>may</u> require medical consultation and antibiotic prophylaxis.
Pwoblèm ki site nan bwat sa a ka nesesite konsiltasyon medikal ak pwofilaksi antibyotik.

- ❑ Innocent Heart Murmur — *Souf kadyak*
- ❑ Asthma — *Opresyon*
- ❑ GI Disorders/Reflux — *Twoub/refli GE*
- ❑ ADHD — *TDA*
- ❑ Autism — *Otis*
- ❑ Down's Syndrome — *Sendwòm Down*
- ❑ Developmental Delay — *Reta nan devlopman*
- ❑ Psychiatric Illness — *Maladi sikyatrik*
- ❑ Drug/Alcohol/Tobacco use — *Izaj dwòg/alkòl/tabak*
- ❑ Spina Bifida — *Spina bifida*
- ❑ Visual/Auditory impaired — *Defisyans vizyèl/oditif*
- ❑ Speech Impediment — *Twoub elokisyon*
- ❑ Recurrent Ear Infections — *Enfeksyon zòrèy repete*
- ❑ Whooping Cough — *Koklich*
- ❑ Eating Disorder — *Twoub alimantasyon*
- ❑ Dizziness/Fainting — *Vètij/evanouyisman*
- ❑ Genetic Disorder — *Twoub jenetik*
- ❑ Pregnant (Currently) — *Ansent (kounye a)*

Other medical conditions (please list/explain):
Lòt pwoblèm medikal (tanpri site/eksplike)

_____
_____
_____
_____
_____
_____

Does your child have any **ALLERGIES** to the following?
*Èske pitit ou a fè nenpòt **ALÈJI** ak sa ki pral site la yo?*

❑ NO KNOWN ALLERGIES — *PA AKOURAN DE ANKENN ALÈJI*
❑ Latex — *Latèks*
❑ Penicillin — *Penisilin*

❑ Medications:_____ — *Medikaman*
❑ Food/Other:_____ — *Manje/lòt bagay*

Does your child take any medications? *Èske pitit ou a pran ankenn medikaman?*

❑ NO MEDICATIONS — *ANKENN MEDIKAMAN*
❑ YES, please list:_____ — *WI, TANPRI SITE YO*

Has your child ever been hospitalized or had surgeries? *Èske pitit ou a te janm entène lopital oswa li te fè operasyon?*

❑ NEVER BEEN HOSPITALIZED — *PA T JANM ENTÈNE LOPITAL*
❑ YES, please specify: _____ — *WI, tanpri presize*

Is this your child's first visit to a dentist? ❑ YES ❑ NO, date of last visit: _____
Èske se premye vizit pitit ou a fè kay dantis? WI NON, dat dènye vizit la

How many times per day does your child brush his/her teeth? ❑ 0 ❑ 1 ❑ 2 ❑ ≥3 Adult Supervision? ❑ Yes ❑ No
Konbyen fwa pa jou pitit ou a bwose dan l? Sipèvizyon adilt? Wi Non

How many times per day does your child floss his/her teeth? ❑ 0 ❑ 1 ❑ 2 ❑ ≥3 Adult Supervision? ❑ Yes ❑ No
Konbyen fwa pa jou pitit ou a itilize fil dantè nan dan li? Sipèvizyon adilt? Wi Non

Has your child ever had any trauma or injuries to the mouth or teeth? *Èske pitit ou a te gen nenpòt twomatis oswa blesi nan bouch oswa dan l yo?*

❑ NO PAST TRAUMA/INJURIES *ANKENN TWOMATIS/BLESI*
❑ YES, please specify: _____ *WI, tanpri presize*

Does your child currently have any dental pain? ❑ NO PAIN ❑ YES, please specify: _____
Èske pitit ou a gen doulè nan bouch li kounye a? ANKENN DOULÈ Wi, tanpri presize

Does your child have any of the following habits? ❑ NONE OF THE BELOW APPLY
Èske pitit ou a genyen nenpòt nan abitid ki site la yo? PA GEN ANKENN NAN SA KI SITE YO KI APLIKAB

❑ Thumb/Finger Sucking *Souse pous/dwèt*
❑ Lip Biting/Sucking *Souse/mòde po bouch*
❑ Mouth Breathing *Respire nan bouch*
❑ Nail Biting *Manje zong*
❑ Teeth Grinding/Clenching *Grense/sere dan*
❑ Pacifier Use *Itilize sison*
❑ Snores while sleeping *Wonfle pandan l ap dòmi*
❑ Protrudes Tongue *Lonje lang li deyò*

Does your child fall asleep with the bottle or sippy cup in his/her mouth? ❑ NO ❑ YES
Èske dòmi konn pran pitit ou a pandan l gen bibwon an oswa goblè a nan bouch li? NON WI

Insurance Information

Enfòmasyon asirans

(Note: We do not bill multiple insurances)
(Note: Nou pa voye fakti bay plizyè asirans)

Do you have insurance coverage for your child? ❑ Yes ❑ No
Èske w genyen kouvèti asirans pou pitit ou a? Wi Non

❑ I have already provided this information *(skip below fill-in section; read below, sign and date)*
Mwen te deja bay enfòmasyon sa a (sote pati pou ranpli anba a; li sa ki anba a, siyen epi mete dat)

Policy Owner Name:_____ Date of Birth: _____
Non moun ki gen asirans lan *Dat nesans*

Insurance Company: *Konpayi asirans lan* _____

Policy Number: _____ Group Number:_____
Nimewo polis asirans lan *Nimewo gwoup*

Insurance Co. Address:_____ City: _____ State: _____ Zip: _____
Adrès konpayi asirans lan *Vil* *Eta* *Kòd postal*

Insurance Co. Phone: *Telefòn konpayi asirans lan* _____

FOR PATIENTS WITH DENTAL INSURANCE/ POU PASYAN KI GEN ASIRANS DANTÈ:

I understand that the American Pediatric Dental Group uses all resources available to them to verify my insurance, however, those resources do not provide a guarantee of payment. All claim payments are determined at the time of claim submission. Furthermore, I certify that my child is covered by the above named insurance company and I assign directly to American Pediatric Dental Group all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature and all my insurance submissions, whether manual or electronic. Should the account be referred to any attorney for collection, the undersigned shall pay reasonable attorney's fees and expenses.
Mwen konprann American Pediatric Dental Group itilize tout resous ki disponib pou yo ka verifye asirans mwen, sepandan resous sa yo pa bay yon garanti pou pèman. Yo detèmine pèman reklamasyon yo nan moman yo soumèt reklamasyon an. Anplis de sa, mwen sètifye pitit mwen an kouvri nan konpayi asirans ki site anwo a epi mwen asiye dirèkteman bay American Pediatric Dental Group tout benefis asirans yo ta dwe peye m. Mwen konprann mwen responsa pou pèman sèvis yo ban mwen an epitou mwen responsab pou m peye nenpòt kotpa ak franchiz asirans mwen an pa kouvri. Lamenm mwen otorize dantis la pou l pibliye tout enfòmasyon ki nesesè pou l ka resevwa pèman benefis yo. Mwen otorize itilizasyon siyati sa a ansanm ak tout enfòmasyon yo soumèt bay asirans mwen an, kit se manyèl kit se elektwonik. Si yo ta voye kont lan bay nenpòt avoka pou fè koleksyon lajan mwen dwe, moun ki siyen anba a pral peye frè ak depans rezonab avoka a.

PLEASE NOTE/TANPRI NOTE:

Payment in **FULL** is expected at the time of dental treatment. The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been made. Since we reserve a special time to offer quality treatment for your child, patients with *two or more* broken or cancelled appointments without a minimum 24-hour notice will result in *discontinuation of any further dental services*, except for 30 days of dental emergencies.
*Nou atann pou fè pèman **OKONPLÈ** nan lè ou resevwa tretman dantè a. Paran oswa gadyen ki akonpaye timoun nan responsab pou pèman nan lè yo resevwa sèvis la amwenske gen aranjman ki te deja fèt alavans pou sa. Piske nou rezève yon tan espesyal pou nou ka bay pitit ou a tretman de kalite, pasyan ki anile oswa ki pa vini nan de (2) randevou oswa plis, san yo pa bay yon notis 24 èdtan pou pi piti, nou pral oblije sispann tout lòt sèvis dantè, eksepte pou 30 jou kadijans dantè.*

I attest that all of the information provided by me in this New Patient Packet is accurate and correct to the best of my knowledge. I am aware that this information will be kept confidential. It is my responsibility to inform this office of any changes in my child's medical history. I authorize the dental staff to perform any necessary dental services that my child may require.
Mwen sètifye tout enfòmasyon mwen bay nan pakè pou nouvo pasyan sa a egzat epi kòrèk selon tout konesans mwen. Mwen konnen yo pral kenbe enfòmasyon sa a konfidansyèl. Se responsablite pa m pou m enfòme ofis sa a si te gen ankenn chanjman nan antesedan medikal pitit mwen an. Mwen otorize pèsonèl dantè a pou l fè tout sèvis dantè ki nesesè pitit mwen an bezwen.

Name/Non: _____

Signature/Siyati: _____ Date/Dat: _____