



Child Registration

Patient (Child) Information

First Name	Last Name	Middle Name
-	-	-
Gender	Date of Birth	Age
-	-	-

Responsible Party (Parent/Legal Guardian Information):

First Name	Last Name	Middle Name
-	-	-
Street Address 1	Street Address 2	City
-	-	-
State	ZIP Code	Home Phone
-	-	-
Work Phone	Extension	Cellular Phone
-	-	-
Date of Birth	Social Security Number	Driver's License
-	-	-
Email		
-		

Tick all that apply:

Parent/Legal Guardian is also a Policyholder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance Information:

Name of Insured		
-		
Insured	<input type="checkbox"/> Child <input type="checkbox"/> Other	
If Others, Please specify	Insured Social Security Number	Policy ID
-	-	-
Insured Date of Birth	Home Address (if different than above)	Home Phone (if different than above)
-	-	-
Employer	Employer Address	Insurance Company
-	-	-
Insurance Company Address		
-		

Secondary Insurance Information (if any):

Name of Insured		
-		
Relationship to Insured	<input type="checkbox"/> Child <input type="checkbox"/> Other	
If Others, Please specify	Insured Social Security Number	Policy ID
-	-	-

Insured Date of Birth

-

Home Address (if different than above)

-

Home Phone (if different than above):

-

Employer

-

Employer Address

-

Insurance Company

-

Insurance Company Address

-

Electronic signature of the Parent / Guardian
(ESign)

Date :



Witkowski Dental

DR. LEON J. WITKOWSKI III, D.D.S.

Leon J. Witkowski III, D.D.S.

Leslie Clevenger, D.D.S.

Emili Hester, D.D.S.

Phone: 708-479-9888

info@witkowskidental.com

Receipt of Notice of Private Practices and current Office Policy Written Acknowledgement Form

I, _____, have received and/or read a copy of
Notice of Private Practices and Office Policy.

Signature of patient or guardian

Date: _____

A HIPPA booklet is available upon request

19665 S. LA GRANGE ROAD, MOKENA, IL 60448

LJWITKOWSKIDENTAL@GMAIL.COM • 708.479.9888 • FAX 708.479.8900



Witkowski Dental

Financial Policies

Our dental office files with all PPO insurance companies.

However, we are NOT in network with any company.

You will receive out of network benefits when submitting claims.

Initials: _____

Our business office will provide a complimentary **pre-treatment authorization** upon your request. However, even a preauthorization does not guarantee payment from your insurance company. For your convenience, we will also file your claim for you. We require photo identification and current insurance information to promptly file your claim. When insurance is involved, we are obligated to collect co-payments, co-insurance as well as deductibles as stated by your insurance company. **Even though we do all we can to work with you and your insurance company, ultimately, you are responsible for payment of any dental procedures or services.**

Initial: _____

Patients without insurance:

There are **multiple options** available for you even without dental insurance. The following options are available to you in order to keep your account current.

1. We accept personal checks, cash, Mastercard, Visa, and Discover credit cards. We also offer Care credit. Care credit is a reasonable short-term financing option available to patients. For more information, please go to carecredit.com or ask about the option in our business office.
2. Payments in full will be expected at the time of treatment. When paying in full we offer a 5% discount applied at the time of treatment.
3. For major dental treatment, we require 1/2 of the fee to be paid at the time of service and financial arrangement(s) on balances to be discussed with the business office.

Initials: _____

Patients with insurance:

The doctor does not have a contract with any insurance company. However, that does not mean your insurance provider will not pay on treatment. Once insurance provides payment the remaining balance will become your obligation. It is the responsibility of the patient to make sure that he/she pays on time. Patients with insurance are still able to take advantage of Care credit, a 0% short term financing option, to pay their remaining balance. Please visit carecredit.com or ask our business office for more details.

All statements and financial obligations are the responsibility of the patient. If your insurance has changed, it is your responsibility to notify our office with the new information. We make every effort to file and track your insurance. If, for some reason, insurance does not pay within a reasonable amount of time (60 days), the balance is required to be paid by the patient. We understand extenuating or uncontrollable financial circumstances. During tough economic times we are here to discuss options if you need to arrange a financial solution. We pride ourselves on the personal relationships we have with our patients and we ask you respect the agreed upon financial arrangement. Lack of communication in regards to your account, will require us to refer to a third-party collection agency.



Witkowski Dental

Insurance checks sent to the subscriber

As an out of network provider, there are insurance companies that send insurance payment checks to the subscriber. Here is what your choices are should your insurance send payment to the subscriber on file:

The checks will be delivered via USPS and you have 2 choices on what to do with the payments.

- Deposit the check and provide payment in full to the rendering provider with your preferred form of payment.
- Endorse the check and provide it to us, the providing office, and pay the remaining balance with your preferred form of payment for the remaining balance.

We kindly request that you forward the full amount of the insurance payment(s) to our office as soon as possible. A reminder, again, these checks are payments for services rendered. We are happy to extend payment plans for your patient portion, but these checks are required upon being issued and your account subject to being sent to a collection agency. **We do not payment plan insurance checks.**

Signature: _____ Date: _____



Childs Demographic Information - 2

First Name -	Middle Initial -	Last Name -
Does your child go by a nickname? A preferred name? -	Birthdate: -	Age: -
Sex -	Home address: -	City -
State -	ZIP Code -	Phone number used for appointment reminders: -
Name of school or daycare: -	Child lives with: -	Person responsible for payment on account: -

Information regarding parent/guardian #1

Parent/Guardian #1 full name: -	DOB: -	Email -
Cell phone: -	Relationship to child: -	Legal custody of a child? -
Same address as a child? If not, please provide your permanent address. -		

Information regarding parent/guardian #2

Parent/Guardian #2 full name: -	DOB: -	Email -
Relationship to child: -	Legal custody of a child? -	Same address as a child? If not, please provide your permanent address. -
Emergency Contact name and phone number: -	Reason for your child's dental visit: -	Sometimes we make conversation by talking about upcoming holidays, cartoon characters, toothfairy, etc. Is this OK with you? -
What is a favorite something we can talk to your child about to make him/her comfortable? -		

CHILD'S HEALTH HISTORY

Is your child under the care of a medical doctor at this time? -	Date of child's last exam? -	Name of child's pediatrician: -
Previous hospitalizations: -	Has your child received general anesthesia? -	Has your child ever had excessive bleeding requiring special treatment? -

Has your child ever been diagnosed with a heart condition or heart murmur? If yes, please describe the reason/procedure/any complications.

-

Is your child allergic to the following:

Food allergy?

-

Ibuprofen/Motrin

-

Lanolin

-

Penicillin

-

Rubber/Latex

-

Seasonal

-

Silver

-

Sulfa

-

Wool

-

None of the above

-

IF your child has an allergy not listed above please describe in this section.

-

Please list and describe the purpose for the MEDICATION(S) your child is on:

-

Medical Conditions: Does your child have any of the following conditions

ADHD/ADD

-

Anemia

-

Anxiety

-

Autism

-

Bleeding Disorder

-

Blood Disease

-

Bronchitis

-

Cerebral Palsy

-

Cleft lip/palate

-

Cystic fibrosis

-

Diabetes

-

Dizzy spells/fainting

-

Eating disorder

-

Eczema/psoriasis

-

Head injury

-

Hearing Impairment

-

Heart condition

-

Heart disease

-

Heart Murmur

-

Hemophilia

-

High Blood Pressure

-

Kidney disease

-

Liver Disease

-

Low Blood Pressure

-

Mouth breathing

-

Nervous disorder

-

Nutrient deficiency

-

Psychiatric disorder

-

Respiratory problems

-

Sickle cell anemia

-

Sinus trouble

-

Spina Bifida

-

Stomach problems

-

Stomach ulcers

-

Substance abuse

-

Thyroid problems

-

Tumors

-

Vision impairment

-

Pregnant

-

Cancer

-

Chemotherapy treatments

-

Radiation

-

Stroke

-

Does your child have a medical condition NOT listed above? Please explain if so.

-

Does your child have epilepsy or seizures? If so, when was the last seizure?

-

Does your child have asthma? If so, when was the last attack?

-

Which of the following food or drink does your child consume daily?

Gatorade/sport drink

-

Juice

-

Soda/energy drink

-

Bottled water

-

Tap water

-

Milk

-

Flavored milk

-

Sparkling water

-

Dried fruit/raisins

-

Cereal/granola bar

-

Gummies/vitamin gummies

-

Fruit snacks

-

Cookies/crackers

-

None

-

BEHAVIORAL /EMOTIONAL HEALTH INFORMATION

Please list any specific behavioral challenges of which you would like the dental team to be aware.

-

SENSORY ISSUES

Please list any specific sounds to which your child is sensitive.

-

Does your child prefer quiet?

-

Is your child sensitive to motion and moving? Ex: dental chair moving up, down, back, forward

-

Does your child have specific oral sensitivities? Ex: gagging, taste

-

Please provide us with any additional information that may help us prepare for a successful dental visit.

-

CHILD'S DENTAL HISTORY

Is this your child's 1st dental visit? If not, when was the last visit and how did it go?

-

Has your child had dental xrays in the past 6 mts? If so, how may we obtain them?

-

Do you have concerns about your child's dental health? If so, please describe.

-

Is your child currently experiencing any dental problems? If so, please describe.

-

Do you give consent for flouride?

-

Do you give consent for dental xrays if needed at your child's first visit with us?

-

How often does your child brush?

-

Does your child use fluoridated toothpaste?

-

Does your adult assist your child with brushing and flossing?

-

Does your child drink city water?

-

Has your child experienced any of the following?

Pacier use

-

Finger sucking

-

Thumb sucking

-

Nail biting

-

None

-

Does your child go to bed with a sippy cup with anything but water?

-

Has your child ever worn an orthodontic appliance?

-

Does your child wear a mouthguard for sports?

-

Does your child get cold sores/ fever blisters?

-

Has your child had a dental injury? If so, please describe.

-

Signature (ESign)

Date :



Request And Consent For Dental Treatment - 1

Patient First Name

-

Patient Last Name

-

Birth Date:

-

Thank you for choosing Witkowski Dental with your child's dental care. Please take me to ll out the following new patient intake form so we can get to know your child beer!

Request And Consent For Dental Treatment

Please read the request and consent prior to signing. Before signing please ask questions to clarify any information.

- 1.) I request and authorize dental treatment for my child by Dr. Witkowski and/ or Dr. Clevenger
- 2.) I understand I will have multiple opportunities to discuss proposed treatment and the dental issues, the cost, the planned procedures and the benefits to be expected from the proposed treatment plan.
- 3.) I authorize the taking of x-rays, the use of topical anesthetic, and the use of nitrous oxide if it is considered necessary to treat my child.
- 4.) It is unusual but possible for complications to occur. The following are included but not limited to: pain or discomfort during treatment, swelling, infecon, bleeding, injury to an adjacent tooth, development of a TMJ disorder, temporary or permanent numbness and allergic reactions.
- 5.) I understand that during a proposed treatment procedure something unexpected may arise that may change the original treatment plan and necessitate additional treatment. If this occurs, we will discuss the change in treatment plan prior to completing the treatment.
- 6.) I understand that the goal of Witkowski Dental is to accomplish dental treatment by the use of warmth, friendliness, humor and gentleness along with kindness. Behavior will be guided using praise, explanation and demonstration of procedures and instruments.
- 7.) I understand should my child become uncooperative during dental procedures with movement of arms, head, legs during treatment and I can not safely provide the treatment proposed, treatment will stop and we will discuss necessary steps to continue proposed treatment.
- 8.) For the purpose of advancing medical-dental education. I give permission for the use of clinical photographs, video, and or xrays of the patient for diagnostic, science, educational, certification for research purposes.
- 9.) I authorize the taking of photographs of my child with a designated clinic camera for marketing and advertising purposes (ie: website, Facebook, Instagram, etc)
- 10.) I give permission for my child to watch any Disney animated movie rated G or PG

Signature (ESign)

Date :