WELCOME!

TELL US ABOUT YOUR CHILD

Today's Date:_________________________ M or F
Home Phone #:_________________Child's Age:___

Child's Birthdate:____________ SSN:___________

Child's Name:______________________________
Last First M
Nickname:__________________________________

Home Address:_______________________________
Street

____
City State Zip
Hobbies:___________________________________
School:______________________ Grade:________

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name:_____________________ Relation:__________
Do you have legal custody of this child? Y or N
Is the child adopted? Y or N
Is the child in a foster home? Y or N
Whom may we thank for referring you?____________
Other siblings seen by us:_______________________
____

Neighbor or Relative Not Living With You

His/Her Name:_______________ Relation:_________
Work Phone:__________ Home Phone:____________
Address:_______________________________________
Street

____
City State Zip

PARENT'S INFORMATION

Parent's Marital Status: □ Married □ Partnered □ Divorced □ Separated □ Widowed □ Remarried □ Single

MOTHER: □ Step Mother □ Guardian Birthdate:____/____/____

Home #:_____________________ Work #:____________________ Cell #:_____________________

Name:_____________________________________ SSN:________________ Driver's License #:_____________
Address:____
Street City State Zip
Employer:____ Length of Employment:_____________
Email:____

FATHER: □ Step Father □ Guardian Birthdate:____/____/____

Home #:_____________________ Work #:____________________ Cell #:_____________________

Name:_____________________________________ SSN:________________ Driver's License #:_____________
Address:____
Street City State Zip
Employer:____ Length of Employment:_____________
Email:____

Person Responsible for Account:_______________________________ Relationship:____________________

INSURANCE INFORMATION

Insurance Co. Name:__________________________________ Phone:______________ Group #:____________
Insurance Co. Address:____
PO Box/Street City State Zip
Policy Owner's Name:__________________________________ Relationship to Patient:____________________
Policy Owner's Birthdate:___/____/____ SSN:________________ Policy Owner's Employer:_______________
Employer's Address:____
Street City State Zip

MEDICAL HISTORY

Child's Physician:____________________________ Phone #:________________ Date of Last Visit:________________

Address:____

Street City Zip

Is the child currently under the care of a physician? □ Yes □ No Please explain:______________________________

Please describe the child's current physical health: □ Good □ Fair □ Poor

Are Immunizations Current? □ Yes □ No

List ALL **drugs or medicines** that the child is currently taking:____

____

____

List all drugs, foods, and materials that the child has an **ALLERGY** to:____

____

Anything you would like to discuss with the Doctor in private? □Yes □No Explain:___________________________

Has the child had/experienced any of the following:

Y N Abnormal Bleeding
Y N AIDS / HIV+
Y N Anemia
Y N Allergies
Y N Any Hospital Stays/Operations/Surgery
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions / Seizures
Y N Attention Deficit/Hyperactivity Disorder
Y N Behavioral or Learning Issues
Y N Blindness / Poor Vision
Y N Cerebral Palsy
Y N Dwarfism
Y N Muscular Dystrophy

Y N Diabetes
Y N Epilepsy
Y N Handicaps / Disabilities
Y N Hearing Impairment/Deafness
Y N Heart Murmur
Y N Hemophilia / Excessive Bleeding
Y N Hepatitis
Y N High Blood Pressure
Y N Hives / Rash
Y N Kidney Problems
Y N Liver Problems
Y N Stomach Problems
Y N Bladder Problems
Y N Developmental Delays
Y N Psychological Problems
Y N Head Trauma / Brain Injury
Y N Artificial Joints

Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Uses Steroids
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Sickle Cell Anemia
Y N Birth Defects
Y N Tonsillitis
Y N Tuberculosis (TB)
Y N Autism
Y N Artificial Heart Valve
Y N Fainting
Y N Down Syndrome
Y N Spina Bifida
Y N Birth Defects

Please discuss any serious medical problems the child experiences/ed:_____________________________________

____

DENTAL HISTORY

Is the child currently in **PAIN**? □ Y □ N What is the primary reason for today's visit? __________________________

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ)? □Y □ N

Is this your child's first dental visit? □Y □ N

Previous / Present (circle) Dentist: ____________________________________ Date of Last Visit: _________________

Why did you leave your previous dentist?____

Has your child had regular dental exams and cleanings? □Y □ N Date:_____________________

Were dental x-rays taken? □Y □ N Date: _____________________

Has the child experienced problems with previous dental work? □Y □ N

Is the child's water fluoridated? □Y □ N Is the child taking fluoride supplements? □Y □ N

How often are your child's teeth brushed per day? □ Once □ Twice □ After each meal □ None

Do you help your child floss daily? □Y □ N

Does / did your child have any of the following habits?

Y N Lip sucking / biting
Y N Nail biting
Y N Chewing on objects
Y N Injury to mouth, teeth or head
Y N Bleeding gums

Y N Clenching / Grinding Teeth
Y N Pacifier Use
Y N Breast or bottle fed for more than 1 yr
Y N Thumb / Finger sucking

Y N Tongue / Cheek biting
Y N Speech problems
Y N Tongue Thrust
Y N Mouth breather

REVIEWED BY DOCTOR: _________________

AUTHORIZATIONS
I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform necessary dental services my child may need. My method of payment will be:
______________________________.

X____
Signature of parent or guardian   Date

I certify that my child is covered by _____________________ Insurance Co. and I assign directly to this office all insurance benefits, if any, 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 herby authorize the dentist to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

X____
Signature of parent or guardian   Date

Office Policies

We have established the following office policies. Please place your initials by each to indicate that you have read them.

____ Treatment will not be performed without a parent or legal guardian present during the appointment time.

_____ Payment and/or co-payment are required in full at the time services are provided.

_____ At least **48 hours advance notice** is required for all appointment changes or cancellations. Otherwise, a **$50 fee** is charged for each appointment so affected.

_____ Valid identification is required for all personal checks. Returned checks will be subject to the terms and conditions of the electronic check acceptance company used in this office, including any fees charged directly by that company.

_____ Past due accounts (having a balance due for more than 60 days) will be charged 1.5% interest per month until such accounts are reconciled. Delinquent accounts (having a balance due for more than 90 days) will be transferred to a collection agency. Any and all charges incurred in the pursuit of the debt by any third party will be the full responsibility of the account holder.

_____ I understand that payment for services is due at the time that services are rendered. Charges are ultimately my responsibility. I understand that my insurance enables me to be seen at your office and I will be responsible for any balance which my benefits do not cover. I also understand that, as a courtesy, our office will file my insurance for me.

_____ The following procedures may have limited or no coverage by your insurance company: 1) composite (white, tooth-colored) fillings on back teeth 2) nerve treatments (pulpotomy or pulpectomy) 3) sealants 4) nitrous oxide/laughing gas 5) orthodontic treatment (expander, Hawley, RPE, etc.) and 6) space maintainers (pedo partials, band and loop, distal shoe, etc.).

_____ We attempt to ESTIMATE your insurance benefits as accurately as possible. However, changes in benefits and exclusions, which may be unique to your policy, may result in a refund or additional balance due after your insurance has paid.

_____ Insurance is not easy to understand. It is wonderful to have, but it is ultimately your responsibility to understand how it pays for your child's dental services. We are delighted to help you, BUT please understand that we are ESTIMATING about certain coverage. You may want to contact your insurance company directly. Again ASK for help, if you need it.

I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.

x____
Signature of parent, guardian or responsible party   Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICES

SECTION A: The Patient

Name of Patient: ____

Address: ____

Telephone: ____

Email: ____

Social Security Number: ____

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice

I, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.
Signature: ____ Date: ______________

If a personal representative signs this authorization on behalf of the individual, complete the following:
Personal Representative's Name: _______________________________________

Relationship to individual: ____

SIGNATURE

I attest that the above information is correct.
Signature: ____ Date: _____________
Print name: ____ Title: _____________