WELCOME

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on a preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

1. Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ___/___/_____ Child's Age: _____

Nickname: _____ ❑ Male ❑ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____

Child's Home Address: _____

_____
City State Zip

2. General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we Thank for referring you? _____

Other siblings: _____

Previous/Present Dentist: _____ Last Visit Date: _____

Dentist's Phone #: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (_____) _____

Address: _____
City State Zip

3. Parent's Information

Person Responsible for Account: _____ Parent's Marital Status ❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Divorced ❑ Seperated

❑ Father ❑ Step Father ❑ Guardian

Name: _____ Birthdate: _____

Address: (If different than Child's) Hm #: (____) _____

_____

_____
City State Zip

SS #: _____ DL#: _____

Wk #: (____) _____ Ext: ___ Cell/Other #:(____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (___) _____

Group # (Plan, Local, or Policy #): _____

❑ Mother ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: _____

Address: (If different than Child's) Hm #: (____) _____

_____

_____
City State Zip

SS #: _____ DL#: _____

Wk #: (____) _____ Ext: ___ Cell/Other #:(____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (___) _____

Group # (Plan, Local, or Policy #): _____

4. Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment 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 on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Guardian Date

Continued on Back

5. Dental History

Why did you bring the child to the dentist today? _____

_____

Is the child currently in pain? ❑ Yes ❑ No

Does the child require antibiotics before dental treatment? ❑ Yes ❑ No

Has the child ever had a serious/difficult problem associated with previous dental work? ❑ Yes ❑ No

How often does your child brush their teeth per day? _____

Floss per day? _____

Do you help? ❑ Yes ❑ No

How often does your child snack per day? _____

What type of snacks? _____

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain/tenderness in his/her jaw joint(TMJ/TMD)? ❑ Yes ❑ No

Child's Physcian: _____

Phone #: (_____)_____Date of Last Visit: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all prescription/over the counter or herbal supplement drugs that the child is currently taking: _____

_____

Aside from items listed, please list all drugs/things that the child is allergic to: _____

_____

_____

Yes No Latex | Yes No Metals/Nickel | Yes No Plastic

6. Medical History

❑ Yes ❑ No	Abnormal Bleeding/Hemophilia	❑ Yes ❑ No	Handicaps/Disabilities
❑ Yes ❑ No	ADD/ADHD	❑ Yes ❑ No	Hearing Impairment
❑ Yes ❑ No	AIDS/HIV+	❑ Yes ❑ No	Heart Murmur
❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Hepatitis
❑ Yes ❑ No	Any Hospitalizations or Operations?	❑ Yes ❑ No	High Blood Pressure
		❑ Yes ❑ No	Skin Rash/ Hives
❑ Yes ❑ No	Artificial Bones/Valves	❑ Yes ❑ No	Kidney Problems
❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Liver Problems
❑ Yes ❑ No	Autism	❑ Yes ❑ No	Lupus
❑ Yes ❑ No	Cancer	❑ Yes ❑ No	Measles
❑ Yes ❑ No	Congenital Heart Defect	❑ Yes ❑ No	Mitral Valve Prolapse
❑ Yes ❑ No	Convulsions/Seizures	❑ Yes ❑ No	Mononucleosis
❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Premature Birth
❑ Yes ❑ No	Delayed Development	❑ Yes ❑ No	Prosthetics
❑ Yes ❑ No	Down Sydrome	❑ Yes ❑ No	Rheumatic Fever
❑ Yes ❑ No	Emotional Problems	❑ Yes ❑ No	Scarlet Fever
❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Tuberculosis (TB)
❑ Yes ❑ No	Exposed to HIV, but Neg		

Are the child's immunizations current? ❑ Yes ❑ No

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

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

_____

_____

Does your child currently have any of these habits?

❑ Yes ❑ No	Bottle/Sippy Cup	❑ Yes ❑ No	Nursing
❑ Yes ❑ No	Chewing on Objects	❑ Yes ❑ No	Pacifier
❑ Yes ❑ No	Clenching/Grinding Teeth	❑ Yes ❑ No	Speech Problems
❑ Yes ❑ No	Lip Sucking	❑ Yes ❑ No	Thumb/Finger Sucking
❑ Yes ❑ No	Mouth Breather	❑ Yes ❑ No	Tongue/Cheek Biting
❑ Yes ❑ No	Nail Biting	❑ Yes ❑ No	Tongue Thrust

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

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 change in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian Date

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

_____ _____

Signature of Dentist Date

Dentist's Comments: _____

_____

Financial arrangements are both necessary and beneficial in maintaining a sound professional relationship which ultimately benefits everyone involved.

We wish to inform you of our office policy in this regard.

1. On the initial visit for examination, consultation, x-rays and prophylaxis or emergency treatment, the charges are payable at that visit. For those patients with dental insurance, you will be responsible for the share your insurance company won't cover at that visit.

2. At each consecutive visit, you will be responsible for all charges at each visit. For those with dental insurance, you will be responsible for the patient share, at time of scheduling.

3. You may us your VISA, MASTER CARD, AMERICAN EXPRESS, or DISCOVER.

4. If necessary, other financial options are available.

5. If a check is returned to us by the bank for any reason, a $35.00 return check charge will be added to the amount issued.

6. We need to precollect patient portion prior to scheduling appointments will all the doctors.

FOR PATIENTS WITH INSURANCE

We will bill your insurance company for you.

At each visit, we will give you an estimate of what your insurance company will pay for each procedure. Keep in mind that it is an ESTIMATE, and sometimes insurance companies pay on a lower fee schedule. In that event, you will be responsible for what the insurance company didn't cover.

In the event you records or x-rays need to be duplicated and transferred to another office, they will be subject to a $31.00 fee.

Signature _____ Date_____

Acknowledgement of Receipt of Notice of Privacy Practices

*****You may refuse to sign this acknowledgment*****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
(please print name)

_____
(Signature)

_____
(Date)

For Office Use Only

We attempted to obtain written Acknowledgement of Receipt of Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign
_____ Communication barriers prohibited obtaining the acknowledgement
_____ An Emergency situation prevented us from obtaining acknowledgment
_____ Other (please specify): _____
_____
_____
_____

_____
Employee Name

_____
Office Name

_____
Employee Signature

_____
Date