Patient Information

Patient Name:_____ Date:_____ ☐ Male ☐ Female
Last First MI

Social Security / ID #: _____ Birthday: _____ E-mail _____

Phone (Home): _____ Work: _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Medical Dental Histories

Date of last Dental visit: _____ Reason for this visit: _____

Has your child ever had any of the following? Please check all that apply:

☐ AIDS / HIV	☐ Epilepsy / Seizures	☐ Latex Allergy	☐ Tumors
☐ Adverse Drug Reaction	☐ Excessive Bleeding	☐ Learning Disorders	☐ Ulcers
☐ Allergies _____	☐ Fainting	☐ Liver Disease	☐ Penicillin Allergy
_____	☐ Head Injuries	☐ Mental Disorders	☐ Codeine Allergy
☐ Anemia	☐ Headaches	☐ Radiation Treatment	☐ Frequent Infections
☐ Asthma	☐ Heart Disease	☐ Respiratory Problems	☐ Fluoride Supplement
☐ Blood Disease	☐ Heart Murmur	☐ Rheumatic Fever	☐ Oral / Finger Habits
☐ Cancer	☐ Hepatitis	☐ Sensory Disorders	Other
☐ Congenital Birth Disorders	☐ High / Low Blood Pressure	☐ Sinus Problems	☐ _____
☐ Diabetes	☐ Jaundice	☐ Stomach Disorders	
☐ Endocrine Disorders	☐ Kidney Disorders	☐ Transfusions	☐ _____

- Has your child ever had any complications or adverse reactions following dental treatment? ☐ Yes ☐ No
  If yes please explain: _____
- Has your child ever been admitted to a hospital or needed emergency care during the past 2 years? ☐ Yes ☐ No
  If yes please explain**:** _____
- Is your child now under the care of a physician? ☐ Yes ☐ No
  If yes please explain: _____
- Name of Physician: _____ Phone: _____
- Does your child complain of any soreness or clicking sound when eating? ☐ Yes ☐ No
  If yes please explain: _____
- Does your child nurse or use a bottle? ☐ Yes ☐ No • Do they complete their own oral hygiene? ☐ Yes ☐ No
- Has your child ever received any facial or oral traumatic injuries? ☐ Yes ☐ No
  If yes please explain: _____
- Is your child at a school grade level appropriate with their age, do they socialize well with other children? ☐ Yes ☐ No
  If no please explain: _____
- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes please explain: _____
- Please list all medications your child is currently taking: _____
- Are there any Social, Cultural or Religious beliefs that may inhibit treatment? ☐ Yes ☐ No
  If yes please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my child's health, I will inform the doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Parenting Adult Information

Name: _____ DOB: _____ Social Security #: _____

Phone (Home): _____ Work: _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Parenting Adult Information

Name: _____ DOB: _____ Social Security #: _____

Phone (Home): _____ Work: _____ Ext: _____ Cell: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Parental Guardian Information

Are there any custody restrictions that this office needs to be aware of? _____

Please provide names of individuals that you do not permit this office to release information to: _____

In your absence who has permission to bring and/or approve treatment for your child: _____

Insurance Information

Name of primary Insured: _____

Insurance plan name, address and phone: _____

_____

HIPPA Compliancy

This office follows all current HIPPA procedures and guidelines to protect your health information. A copy of the full article is available for you at the front desk if needed. By completing and signing this form you grant this office the authorization to use your protected health information in a manner consistent with current guidelines. INTL _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) or $5 (whichever is greater) on the unpaid balance will be charged on all accounts, unless previously written financial arrangements are satisfied. The office reserves the right to charge $25 for all missed or cancelled appointments without a 24-hour advanced notice. There will be a $25 fee for all returned checks.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay for all costs of collection in including any and all reasonable attorney fees, not to exceed fifty percent (50%) of the balance assigned, if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home, work or on my cell to discuss treatment, account and/or insurance matters.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party