## Patient Information

Child's Name: _____ Date of Birth: _____

Preferred Name: _____ School Grade:_____

Address: _____

City: _____ State: _____ZIP:_____

Social Security #:_____

Father's name: _____ Phone number: _____

SS#: _____ Employer:_____

Email Address:_____

Mother's name: _____ Phone number: _____

SS#: _____ Employer:_____

Email Address:_____

Responsible Party Name: _____

Phone number:_____ Relationship to Patient: _____

Who may we thank for referring you to our office?_____

## Dental Insurance Information

Name of Policy Holder:_____

Relationship to Patient: o Self o Spouse o Child o Other _____

Policy Holder SS# or Alternate ID#: _____ Policy Holder Date of Birth:_____

Name of Insurance Co: _____ Policy Holder Employer: _____

Insurance Phone#: _____

## Dental History

Date of your last dental visit: _____ Dentist: _____

At what age did your child stop using a nursing bottle? _____Does your family drink well or city water?_____

How often are your child's teeth brushed per day?_____By whom? _____

__Yes __No Has your child experienced any unfavorable reations from previous dental or medical care? If yes, explain_____

_____

__Yes __No Has your child had a toothache recently? If yes, explain _____

--OVER--

__Yes __No Has your child received trauma to his/her teeth? If yes, explain _____

__Yes __No Does your child ever have popping, clicking, or pain in the jaw joint?_____

__Yes __No Does your child have any history of mouth breathing, thumb sucking, finger sucking, lip/nail biting or other habits? If yes, please underline.

__Yes __No Is your child taking any vitamins or fluorides?

__Yes __No Does your child have a dental condition about which you are especially concerned? If yes, explain _____

_____

__Yes __No Is there anything else about your child you think I should know to better plan his/her dental treatment? If yes, explain

_____

## MEDICAL HISTORY

Condition of the child's general health: _____ Height_____ Weight_____

Child's physician _____Address _____ Telephone # _____

How long since your child's last physical examination? _____

__Yes __No Does your child have physical or mental disabilities? If yes, explain _____

__Yes __No Has your child ever been hospitalized? Date _____ Reason _____

__Yes __No Has your child ever had a blood transfusion? Date _____ Reason _____

__Yes __No Has your child received emergency medical treatment within the last six months? If yes, explain _____

_____

__Yes __No Has your child ever had hearing, sight, speech, or language learning problems? _____

_____

__Yes __No Is your child currently receiving speech therapy? If yes, by whom? _____

__Yes __No Has your child ever received injuries to the head, jaw, mouth, or teeth? If yes, describe _____

_____

__Yes __No Is your child allergic to any medicine or food? If yes, what? _____

__Yes __No Is your child taking any medicine now? If yes, what?_____

**Indicate any of your child's past or present conditions:**

__Yes __No Anemia
__Yes __No Epilepsy
__Yes __No Muscle Disorders
__Yes __No Asthma
__Yes __No Eye Disorders
__Yes __No Nose / Throat Disorders
__Yes __No AIDS
__Yes __No Heart Condition/ Murmur
__Yes __No Rheumatic Fever
__Yes __No Bleeding Tendency

__Yes __No Hemophilia
__Yes __No Skin Disease
__Yes __No Blood Disease
__Yes __No Hepatitis
__Yes __No Sickle-Cell Anemia
__Yes __No Bone Disorders
__Yes __No High Blood Pressure
__Yes __No Stomach Problems
__Yes __No Convulsions
__Yes __No Hyperactivity

__Yes __No Tumors
__Yes __No Diabetes
__Yes __No Kidney Disease
__Yes __No Tuberculosis
__Yes __No Ear Disorders
__Yes __No Liver Disease/ Jaundice
__Yes __No Emotional Problems
__Yes __No Lung Disease
__Yes __No Endocrine Disorders
__Yes __No Other_____


# CONSENT FOR DENTAL TREATMENT

COVID-19 Waiver

I understand that there is presently a public health emergency as declared by the President of the United States and the Governor of this State. I understand that being in public and/or receiving dental treatment at this time may present an increased risk of the transmission and/or the contraction of COVID-19. While the Provider will take the necessary precautions in order to reduce the risk of such transmission during any dental treatment and/or procedure, at this time there is no way to guarantee such procedure and/or treatment will be completely risk free.

I hereby knowingly and freely acknowledge, and assume any and all risks, known and unknown, related to the potential contraction of COVID-19 during the dental procedure and/or treatment, and assume full responsibility for such risk. I hereby agree to indemnify and hold harmless the Provider, its employees, officers, owners, doctors, directors, members, managers, members, contractors, agents and/or representative from any and all claims, actions, suits, procedures, costs, expenses, damages and liabilities, including attorney's fees, which may be brought as a result of the dental procedures and/or treatment provided on the date identified below or hereafter as such treatment and/or procedure may be related to the contraction of COVID-19.

The undersigned, on behalf of myself as well as any of my heirs, personal representative or assign, hereby release, waive, discharge, and covenant not to sue the Provider, or any of the provider's employees, officers, owners, doctors, directors, members, managers, contractors, agents and/or representatives for any and all claims, known or unknown, which may be related to the transmission and/or contraction of COVID-19, including but not limited to claims which may result in personal injury, illnesses (including death), loss of income or other property loss.

I have read this document and discussed all of the above with the Provider, and all my questions have been answered to my satisfaction.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

Following the explanation, the discussion, and the answers to my questions, I authorize the Provider to complete the treatment as described.

Patient Signature: _____

Print Patient Name:_____

# Financial Policy

Welcome to our practice! We are pleased you have chosen us, and we are committed to your successful dental health treatment. To achieve this, your assistance and compliance with our payment and insurance coverage policies are necessary.

- Full payment is expected at the time services are rendered.
- You are responsible for determining your insurance coverage.
- Coverage issues can only be addressed by your employer or group plan administrator.
- All deductibles and patient percentages are due before insurance claims are filed.
- It is the patient's responsibility to follow up on denied claims.
- Regardless of insurance coverage, you are responsible for payment on all charges.
- We accept cash, checks, Visa, Mastercard, Discover, and American Express.
- Finance charges may be applied to all balances over 90 days at 1.5%.
- All balances over 120 days are automatically turned over to a collection's agency.
- No minors will be treated without a parent or legal guardian present.

As a courtesy to our patients, we file to the primary insurance company. Please be aware, some insurance plans may not consider the fees charged by this provider to be reasonable and necessary. You are responsible for all charges regardless of insurance company's arbitrary determination of usual and customary. Please be aware, if you do not provide all the necessary insurance information, we will be unable to file your insurance.

I understand I am responsible for paying attorney's fees and all collection expenses incurred and expanded in the event my account is referred to Magistrate Court, an attorney, or a collection agency.

I have read, understand and agree with this financial policy.

Signature: _____ Date: _____

# Missed/Cancelled Appointments

We are a busy practice and often have a waiting list. Our office requires 48 hours' notice for any cancellations. If you have a Monday appointment you must cancel by Thursday at noon.

**Missed appointments have a 3-strike policy; 1st missed appointment is excused. For the 2nd missed appointment you will be charged a $75 fee. After the 3rd missed appointment, we will no longer schedule you and you will be dismissed from our practice.**

I have read this information and agree to adhere to the policies.

Signature: _____ Date: _____

# HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

Patient Name: _____Date of Birth: _____

Name of Parent or Guardian (if different than patient): _____

1. I hereby authorize all health care providers to use and/or disclose the protected health information ("PHI") described below to me or as directed below. The purpose of this request is for personal reasons.

2. I hereby authorize the release of PHI, defined here as the patient's complete dental record, including treatment, prognosis, financial, billing, and insurance information. I understand that my personal billing, financial, and insurance information may be disclosed to those in paragraph 3 in order to be able to process claims with the insurance company and/or for personal reasons.

3. In addition to the authorization for release of my PHI described in paragraph 3 of this Authorization, I authorize disclosure of information regarding my/my child's billing, condition, treatment and prognosis to the following individual(s) (please include caregivers that my accompany children to appointments):

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

   Name: _____ Relationship: _____

4. This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until I am no longer a patient at the practice, or until such time as I render payment for my own treatment, or _____, (date or event) at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule.

7. I understand that my health care provider cannot condition treatment on whether I sign this Authorization. However, if I refuse to sign this Authorization, I understand that payment will be collected at the time services are provided and I will be responsible for filing any claims with my dental insurance company.

Signature: _____ Date: _____