PATIENT FORM - CHILD

Patient Information

PATIENT NAME _____

DATE OF BIRTH _____ AGE _____

Insurance Information

POLICY HOLDER NAME _____

RELATIONSHIP TO PATIENT_____

POLICY HOLDER'S DOB _____ POLICY HOLDER'S SS# _____

POLICY HOLDER'S EMPLOYER _____

INSURANCE COMPANY_____

GROUP # _____ ID #_____

INSURANCE COMPANY PHONE _____

Emergency Contact Information

EMERGENCY CONTACT _____PHONE #_____

RELATIONSHIP TO PATIENT_____

ADDRESS _____

CITY _____STATE_____ ZIP _____

How did you hear about us?

_____

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

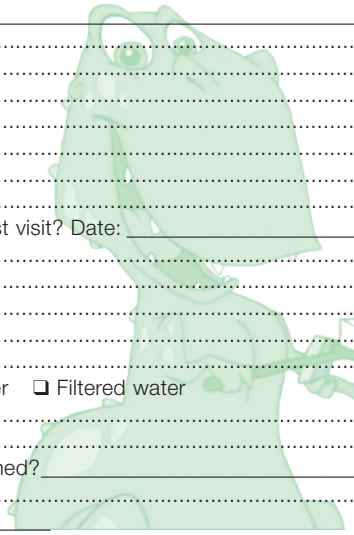
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

Downtown Dental

Patient HIPAA Acknowledgment and Consent

Last Name: First Name: Birthdate:

Date:

Notice of Privacy Practices

I acknowledge that I have been informed of Downtown Dental's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the office if I have a question or complaint. I understand that I may request a copy of the Notice of Privacy Practices at any time. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the Notice of Privacy Practices.

Release of Information

I hereby permit Downtown Dental to release healthcare information for purposes of treatment, payment, or healthcare operations as discussed in the Notice of Privacy Practices. I understand that Downtown Dental may be required by federal, state, or local law to disclose health information. I permit Downtown Dental to release necessary health information for Special Situations as described in the Notice of Privacy Practices.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health information to be disclosed for purposes of communicating results, findings, and care decisions to the individuals listed below. I understand that I may add or remove individuals from this list at any time.

Name	Relationship	Contact Number

_____

Patient/Guardian Signature

Downtown Dental

Patient Financial Responsibility

Last Name: First Name: Birthdate:

Date:

I, _____, hereby assign to Downtown Dental all payments for all services rendered to myself and/or my dependents. I understand that I am responsible for payment of any amount not paid by my insurance company and that billing my insurance company is a courtesy and not an obligation of this office.

I acknowledge that any insurance claims pending beyond thirty (30) days are my responsibility. I will immediately pay the balance if the account balance is more than thirty (30) days past due. I understand that if I make a payment and Downtown Dental thereafter receives payment from my insurance company I will be reimbursed. I understand that if my account is still outstanding after sixty (60) days from the date of service(s) my account may be referred to a collection agency or an attorney for collection unless prior agreements are made.

This office has participating providers for Anthem, Cigna Radius, Delta Denta Premiere, Guardian, Metlife, and United Concordia. If you have dental insurance with companies other than those listed above, you will be responsible for your copayment at the time of service.

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.

* If I begin major treatment that involves lab work, I will be responsible for the fee at that time.

* I understand that Downtown Dental does not accept postdated checks

* Downtown Dental does not make payment plans and payment is expected at every appointment unless otherwise stated

* If sent to collections, I agree to pay all related fees and court costs.

* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.

* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 30 days past due.

* There will be a fee of $35 for all returned checks

* I understand that broken, missed, or cancelled appointments without 24 hours prior notice may be charged a missed appointment fee of $70

* I understand that treatment plans may change. My treatment options will be discussed with me, and I will be responsible for the work actually done.

*I will pay any expected deductible and co-insurance amounts at every office visit.

_____

Patient/Guardian Signature