FAMILY INFORMATION

Full Name of Child____Nickname_____________
Age_________Birthdate__________________________Sex____________Grade_________________
Home Address_________________________________City _____________State________Zip______
Home Phone #_____________________________________Parent Cell Phone #__________________
Father's Name___________________________________Father's Date of Birth_______________
Father's Occupation________________________________Employer__________________________
Business Address____Phone#_____________
Mother's Name__________________________________Mother's Date of Birth_______________
Mother's Occupation_____________________________Employer______________________________
Business Address____
Marital Status: Married_______Single_______Seperated_______Divorced_______Widowed_______
Who referred you to our office?____
Names and ages of other children in your family____
In case of emergency notify (other than parents):
Name____Phone#______________________________

INSURANCE INFORMATION

Guarantor's Name_______________________________ Date of Birth___________________________
Guarantor's SS#_________________________________
Insurance Company______________________________ Claims Address:________________________

MEDICAL INFORMATION

Your Child's health is: Excellent______ Fair_______ Poor_______
Name of child's physician____
Is your child taking any medication at the present time Yes________ No__________
If yes please provide the name of each
medication____
Has your child ever had an unfavorable reaction to a local (Novacaine) or General (gas) anesthetic?
Yes_____________ No______________ If so please describe the situation________________________
____
HAS YOUR CHILD EVER BEEN ALLERGIC TO ANY MEDICINE, FOOD OR
SUBSTANCE?____
____
Has your child had any bleeding problems?____
Has your child had any history of the following:

__Anemia	__Chicken Pox	__Digestive Problem	__Heart problem/murmur
__Asthma	__Chronic sinus problem	__Down's Syndrome	__Kidney Disease
__Autism	__Frequent sinus problems	__Frequent Ear Infections	__Liver Disease
__Bladder Problem	__Chronic Colds	__Epilepsy	__Mononucleosis
__Cancer	__Convulsions	__Fainting	__Muscular Dystrophy
__Cerebral Palsy	__Diabetes	__Hearing Loss	__Rheumatic Fever
__Skin Disorder	__Thyroid Condition	__Tuberculosis	__Measles/Mumps
__ADD/ADHD	__Developmental Delay	__Cognitive Disorder	__Psychological Condition

Please comment on any of the above checked items if you feel it is significant___________________
____
Was the term of pregnancy and birth normal with respect to your child?_________If not please state any complications or problems including prematurity, low birth weight, or medications taken?

Can you offer any other information about your child or family's health which may help us in providing them with appropriate dental care?____

DENTAL INFORMATION

Is this your child's first visit to the dentist? __Yes __No
If not please provide the name of the prior dentist____
Has there been a problem with previous dental care?____
Was any treatment done at previous dentist, if so please describe___________________________________
Does your child have a history of ____Thumb sucking ____Nail or object biting ___Mouth breathing
____Tongue Thrusting ____Speech problems
Has any member of your family had any unusual dental problem____________________________________
How often does your child brush his/her teeth ____
Has your child ever had an injury to his/her face or teeth____
Is your child experiencing any dental pain or discomfort now_______________________________________

PERSONAL INFORMATION

Name of School____
Child's hobbies, interests talents____
Child's temperament: ___Shy ___Fearful ___Calm ___Outgoing
Do you have any questions you would like answered____

CONSENT FOR TREATMENT

I____(name of Parent or Guardian) give permission for

this office to render any necessary dental treatment to my child__________________________________

Signed____________________________________(Signature of Parent) Date_____________________

HIPAA PRIVACY FORM
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

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 our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Cancellation Policy

Dear Parents,

As parents ourselves we realize that unforeseen circumstances often occur with kids. These circumstances often force us to cancel and reschedule appointments. However, with each dental appointment time has been specifically set aside for your child/children. Therefore if you are unable to keep your scheduled appointment we kindly ask that our office be notified a minimum of 24 hours in advance. This will make the time available for other children. Failure to notify us in a timely manner will result in a charge of $75.00 per child being applied to your account. Repeated disregard of this policy can result in dismissal from our practice. Thank you for your understanding in this matter. We recognize that your time is valuable and we ask that you respect that ours is as well. Please sign below to indicate that you have read and accept the terms of this policy.

____

Name (Printed)

____

Signature

____

Date