

pediatric dentistry

bartlett office

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emily m. sheppard, d.d.s.

PATIENT INFORMATION

Patient's full name _____ Preferred name _____ Sex: M F Birth date _____ Age _____

School _____ Grade _____ Child's hobbies/interests/activities _____

Is this your child's 1st dental visit? _____ If not, when was your child's last dental visit? _____

Purpose of today's visit _____ How did you hear about us? _____

With whom does the patient live? _____ Other siblings as patients here _____

Child's physician _____ Physician's phone number _____ Name(s) of pet(s) _____

Whom may we contact (outside of your household) in case of an emergency? Name of Contact _____

Relationship to patient _____ Phone number _____ Address _____

PATIENT'S HEALTH HISTORY

Please check the appropriate box (yes or no):

- | | Yes | No |
|---|--------------------------|--------------------------|
| • Is your child in good health? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does your child have regular medical exams? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Are your child's immunizations current? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Is your child high strung or nervous? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Has your child had a toothache lately? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Has your child ever had surgery or been hospitalized since birth?
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| • Has your child ever had an unfavorable medical or dental visit?
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| • Is your child undergoing medical treatment for a current or previous condition?
If yes, please explain _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| • Is your child currently taking any medication(s)?
If yes, please list _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| • Does/did your child thumb suck, finger suck, or use a pacifier?
If yes, for how long? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| • Was your child bottle fed past age one? | <input type="checkbox"/> | <input type="checkbox"/> |

Please check any applicable boxes:

- | | |
|--|---|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Vision Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Disorder |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Speech Disorder |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Emotional Disorder |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Liver Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disorder |
| <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> Lung Problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Born Prematurely |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Brain Injury |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Allergy Shots |
| <input type="checkbox"/> Food Allergies _____ | |
| <input type="checkbox"/> Allergies to medicine/drugs _____ | |
| _____ | |
| <input type="checkbox"/> Adverse reactions to medicine/drugs _____ | |
| _____ | |
| <input type="checkbox"/> Other health concerns _____ | |

CONSENT FOR TREATMENT/PAYMENT

As parent or guardian of this child, I hereby grant authorization for Dr. Joshua Brink and/or Dr. Emily Sheppard to accomplish necessary dental treatment. Furthermore, I will be responsible for any bill incurred by treatment on this child, including reasonable attorney's fees and costs of collection in the event of default. I understand that payment is expected at the time services are rendered. I authorize this office to file claims on my behalf. I give permission for benefits to be paid directly to Dr. Brink.

Signed _____ Date _____
Responsible Party/Legal Guardian

PARENT/LEGAL GUARDIAN INFORMATION

FATHER

Name _____
Date of Birth _____
Address _____ SS# _____
City, State, Zip _____
Home Phone _____ Cell _____
Work _____ Extension _____
E-mail _____

MOTHER

Name _____
Date of Birth _____
Address _____ SS# _____
City, State, Zip _____
Home Phone _____ Cell _____
Work _____ Extension _____
E-mail _____

DENTAL INSURANCE INFORMATION

This office is happy to cooperate with our families who are covered by dental insurance; however, we have no direct relationship with your insurance company. Please read our separate "Dental Benefits Agreement" form for important information regarding our office's policies regarding insurance.

Is your child covered by dental insurance? Yes No

Primary Insurance Information:

Policy Holder's Relationship to Patient: _____
Employee's Name _____ SS# _____
Policy ID# _____ DOB _____
Employer's Name _____
Employer's Phone Number _____
Insurance Company _____
Ins. Co. Phone Number _____
Address _____

Secondary Insurance Information:

Policy Holder's Relationship to Patient: _____
Employee's Name _____ SS# _____
Policy ID# _____ DOB _____
Employer's Name _____
Employer's Phone Number _____
Insurance Company _____
Ins. Co. Phone Number _____
Address _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ Conduct, plan, and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- ❖ Obtain payment from third party payers.
- ❖ Conduct normal health care operations, such as quality assessments and physician certifications.

I have reviewed your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time. Further more, I realize that I may contact this organization at any time at the address above to obtain current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signed _____ Date _____
Responsible Party/Legal Guardian