pediatric dentistry

fayette / eads office

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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?	☐	☐
• Does your child have regular medical exams?	☐	☐
• Are your child's immunizations current?	☐	☐
• Is your child high strung or nervous?	☐	☐
• Has your child had a toothache lately?	☐	☐
• Has your child ever had surgery or been hospitalized since birth? If yes, please explain________	☐	☐
• Has your child ever had an unfavorable medical or dental visit? If yes, please explain________	☐	☐
• Is your child undergoing medical treatment for a current or previous condition? If yes, please explain________	☐	☐
• Is your child currently taking any medication(s)? If yes, please list________	☐	☐
• Does/did your child thumb suck, finger suck, or use a pacifier? If yes, for how long? ________	☐	☐
• Was your child bottle fed past age one?	☐	☐

Please check any applicable boxes:

☐ Heart Condition	☐ Vision Disorder
☐ Asthma	☐ Hearing Disorder
☐ Autism	☐ Speech Disorder
☐ Down Syndrome	☐ Emotional Disorder
☐ Cerebral Palsy	☐ Thyroid Disorder
☐ Hepatitis	☐ Liver Disorder
☐ Diabetes	☐ Kidney Disorder
☐ Developmental Delay	☐ Blood Disorder
☐ Sickle Cell Anemia	☐ Blood Transfusion
☐ Lung Problems	☐ Tuberculosis
☐ Epilepsy	☐ Born Prematurely
☐ Seizures	☐ Anxiety
☐ Rheumatic Fever	☐ Brain Injury
☐ AIDS	☐ Allergy Shots

☐ Food Allergies________________

☐ Allergies to medicine/drugs________________

☐ Adverse reactions to medicine/drugs________________

☐ 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