Patient Information

*Name____
Last　　First　　MI　　(Preferred)
*Birthdate______________ SS#__________________ *Gender: [ ] M [ ] F
Home Phone______________ *Wireless Phone__________________ Work Phone ______________
Email____
Name of referring DR.? ______________________________

PATIENT ADDRESS

*Address______________________ *City______________________ *State________ *Zip________
Policy Holder Address if different from patient:
Address______________________ City______________________ State________ Zip________

MOTHER'S INFORMATION

*Name______________________________________ *Guardian [ ] Y [ ] N * Step Mother [ ] Y [ ] N
*Birthdate______________ * SS#__________________ DL#______________ * Married: [ ] Y [ ] N
Work Phone______________ * Wireless Phone__________________ * Employer__________________
*Email____

FATHER'S INFORMATION

*Name______________________________________ *Guardian [ ] Y [ ] N Step Father [ ] Y [ ] N
*Birthdate______________ *SS#__________________ DL#______________ * Married: [ ] Y [ ] N
Work Phone______________ * Wireless Phone__________________ * Employer__________________
*Email____

PERSON RESPONSIBLE FOR ACCOUNT

*Name______________________ *Relation ______________________ *Employer______________
*Address______________________ *City______________________ *State________ Zip________
DL#______________ *SS#______________ *Work Phone______________ *Wireless Phone ______________
Emergency Contact ______________________________ *Emergency Phone ______________

PRIMARY INSURANCE POLICY

Patient relationship to policy holder: [ ] Self [ ] Dependent [ ] Child
Subscriber Name______________________________ Subscriber ID # ______________________
Insurance Company ______________________________ Phone______________________
Employer______________________ Group Name______________________ Group #______________
Please present insurance card to receptionist.

SECONDARY INSURANCE POLICY

Your relationship to policy holder: [ ] Self [ ] Dependent [ ] Child
Subscriber Name______________________________ Subscriber ID # ______________________
Insurance Company ______________________________ Phone______________________
Employer______________________ Group Name______________________ Group #______________

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.
The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been made.

*Signature______________________________________ Date______________

Patient Medical History and Information

*Name ____
Last First MI (Preferred)

*Birthdate ______________ SS# ____________________ * Gender: [ ] M [ ] F

*

Name of Medical Doctor: ____________________________ **Phone** ______________

List all the medications or drugs patient is now taking:
[ ] None ____________________________

List all the medications or drugs patient is allergic to:
[ ] None ____________________________

Has your child ever had any of the following medical problems?

[ ] Y [ ] N HANDICAPS/DISABILITIES
[ ] Y [ ] N HEARING IMPAIRMENT
[ ] Y [ ] N HEART MURMUR
[ ] Y [ ] N HEMOPHILIA
[ ] Y [ ] N HEPATITIS
[ ] Y [ ] N HIV+/ AIDS
[ ] Y [ ] N KIDNEY/LIVER PROBLEMS
[ ] Y [ ] N RHEUMATIC/SCARLET FEVER
[ ] Y [ ] N SICKLE CELL DISEASE/TRAITS
[ ] Y [ ] N TUBERCULOSIS (TB)
[ ] Y [ ] N ABNORMAL BLEEDING
[ ] Y [ ] N ADD/ADHD
[ ] Y [ ] N HOSPITAL STAYS
[ ] Y [ ] N OPERATIONS
[ ] Y [ ] N ARTIFICIAL BONES/JOINTS/VALVES
[ ] Y [ ] N ASTHMA
[ ] Y [ ] N CANCER
[ ] Y [ ] N CONGENITAL HEART DEFECT
[ ] Y [ ] N CONVULSIONS/EPILEPSY
[ ] Y [ ] N DRUG ALLERGIES
[ ] Y [ ] N DIABETES

Answer the following questions regarding the child's overall health.

[ ] Y [ ] N IS THE CHILD'S WATER FLUORIDATED
[ ] Y [ ] N DOES THE CHILD TAKE FLUORIDATED SUPPLEMENTS
[ ] Y [ ] N HAS THE CHILD EVER HAD ANY PAIN OR TENDERNESS IN JAW (TMJ/TMD)
[ ] Y [ ] N DOES THE CHILD BRUSH DAILY
[ ] Y [ ] N DOES THE CHILD FLOSS DAILY
[ ] Y [ ] N IS THE CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN
[ ] Y [ ] N HAS YOUR CHILD EVER TAKEN FOSAMAX OR BISPHOSPHONATE
[ ] Y [ ] N HAS YOUR CHILD EVER TAKEN PHEN-PHEN

Does your child have any of the following habits?

[ ] Y [ ] N LIP SUCKING
[ ] Y [ ] N NAIL BITING
[ ] Y [ ] N NURSING BOTTLE HABITS
[ ] Y [ ] N THUMB/FINGER SUCKING
[ ] Y [ ] N TOBACCO USE

[ ] Y [ ] N Is your child allergic to any materials?

Please list: ____________________________

Please discuss any serious medical problems that your child has had: [NONE]

____

Unusual reaction to dental injections? ____________________________

Reason for today's visit ____________________ Is your child in pain? ____________

New patients:

Name of former dentist ____________________ City/State ____________

Date of last cleaning and exam ____________

Signature ______________________________ **Date** ____________

Medical History Update

1. Signature ____________________ Date ______
Comments ____________________________

2. Signature ____________________ Date ______
Comments ____________________________

Permission to Treat

Child's First Name* Child's Last Name* Child's Date of Birth*

Permission to Treat

Due to your child being a minor it is necessary to have signed permission from a parent or legal guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the doctor may deem necessary during the performance of his services.

Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient. Photos and other dental records of my child may be used for teaching or instructional purposes. I give the permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

Parent/Legal Guardian* *Relationship Date*

Minor/ Child Consent

I do hereby request and authorize the dental staff to perform necessary dental service for my child, including x-rays, nitrous oxide (laughing gas) and administration of anesthesia and any services deemed advisable by the doctor, even if I am not present in the operatory during the dental treatment.

Initial here

Dental Treatment

I understand that during the treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary.

Initial here

Financial Agreement/Insurance

I understand that Children's Dentistry of Amarillo is out of network with ALL insurance companies. I understand that Children's Dentistry of Amarillo does not bill third parties, including secondary insurance, medical/accidental insurance, or non custodial parent(s). I understand that Children's Dentistry of Amarillo will file my primary insurance as a courtesy to me. I also understand that payment is due in full at the time of appointment. I accept full responsibility for all fees and services rendered. All accounts post 60 days are subject to a $50.00 rebilling fee. If your account be-comes past due. we will refer to a collection agency to collect the debt. Returned checks will be charge a $30.00 fee.

Initial here

Consent for use and disclosure of Health Information HIPAA PRIVACY POLICY

You have the right to read our Notice of Privacy Practices before you decide whether to sign the consent. I have had full opportunity to read and consider the contents of the consent form and your Notice of Privacy Practices. I understand that by signing this consent form. I am giving my consent to use the disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Initial here

Acknowledgment of receipt of Notice of Privacy Practice and Patients Rights

I have received a copy of this office's Notice of Privacy Practices and Patients Rights.

Initial Here

Delegation of Power by Parent or Guardian

I give my consent to allow person(s) named below other than myself to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services. I understated I can revoke this consent at any time providing written notice.

Persons who have consent in my absence are:

Name **Relationship**

Name Relationship

(Only if Applicable)

Signature of Parent /Legal Guardian * Date