Child New patient Packet

Child Health/Dental History Form

First Name: | Middle Name: | Last Name: | Birth Date:

Parent's/Guardian's Name: | Relationship to Patient: | Address:

City: | State: | Zip: | Cell Phone: | Gender:

Child's Medical History

Problems

- ☐ (TMJ) pain/jaw discomfort
- ☐ ADD / ADHD
- ☐ ADHD
- ☐ Alzheimer's or Dementia
- ☐ Alzheimer`s Disease
- ☐ Anemia
- ☐ Anxiety disorder
- ☐ Anxiety/Nervousness
- ☐ Arthritis
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Autism
- ☐ Bed Wetting
- ☐ Cancer
- ☐ Cancer / tumors
- ☐ Cardiomyopathy (Heart Muscle Disease)
- ☐ Cardiovascular disease
- ☐ Celiac disease
- ☐ Chemotherapy
- ☐ Chronic obstructive pulmonary disease (COPD)
- ☐ Congenital Heart Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Frequent Headaches
- ☐ Gag Reflux
- ☐ Heart Attack
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hormone imbalance or deficiency
- ☐ Infective endocarditis
- ☐ Kidney disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Nursing
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Other
- ☐ Pneumonia
- ☐ Pregnant/planning
- ☐ PREMEDICATION NEEDED
- ☐ Radiation therapy?
- ☐ Rheumatoid arthritis
- ☐ Sensory Disorder
- ☐ Sexually transmitted disease
- ☐ Sickle Cell Disease
- ☐ Sjögren's syndrome
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Stroke
- ☐ Thyroid Disease

Please list any other medical problems not listed above:

Medications

Medication Name: | Comments/Dosage:

Is your child allergic to any of the following?

- ☐ Amoxicillan
- ☐ Cashews
- ☐ Clindamycin
- ☐ Eggs
- ☐ Flouride
- ☐ Latex
- ☐ Local anesthetic
- ☐ Milk
- ☐ Nuts
- ☐ Other
- ☐ Peanuts
- ☐ Penicillin
- ☐ Pollen Dust
- ☐ Seasonal
- ☐ Soy
- ☐ Tree Nuts

How would you describe your child's eating habits?

Does your child have a history of any other illnesses?

If yes, please list:

Is this your child's first visit to a dentist?

- ○ Yes
- ○ No

If it's not your child's first visit, what was the date of their last visit to the dentist?

	Yes	No
Has your child ever received a general anesthetic?	○	○
Does your child have any inher ited problems?	○	○
Does your child have any spee ch difficulties?	○	○

Has your child ever had a bloo d transfusion?	○	○
Is your child physically, mental ly, or emotionally impaired?	○	○
Does your child experience ex cessive bleeding when cut?	○	○
Is your child currently being tr eated for any illnesses?	○	○

	Yes	No
Has your child had any proble m with dental treatment in the past?	○	○
Has your child ever had dental radiographs (x-rays) exposed?	○	○
Has your child ever suffered a ny injuries to the mouth, head or teeth?	○	○
Has your child had any proble ms with the eruption or shedd ing of teeth?	○	○
Has your child had any orthod ontic treatment?	○	○

Does your child use fluoride toothpaste?

○ Yes

○ No

How many times does your child brush their teeth per day?

When are your child's teeth brushed?

Does your child suck their thumb, fingers or pacifier?

○ Yes

○ No

At what age did your child stop bottle feeding?

At what age did your child stop breast feeding?

Does your child participate in any active recreational activities?

NOTE: Both the 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:

Sign

Financial Policy

•FULL PAYMENT IS DUE AT TIME OF SERVICE.

Insurance: Coverage and Co-pays

We provide insurance company billing as a courtesy to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by our team regarding his/her remaining benefit in any such benefit period. For covered services, all co-pays and deductibles must be paid on the day of treatment. Since your insurance company may not cover all costs, we require that you pay any percentage of your balance not paid by your insurance on the day of treatment. For services that are not covered by your insurance, we require that you pay the entire fee the day of your treatment We will attempt to answer any questions we can about your insurance and, to the extent practicable, assist you with insurance billing issues. However, your insurance contract is an agreement between you and your insurance carrier to which we are not a party. In the event that your insurance company does not pay any amounts due for your care, you agree you are financially responsible for such amounts, and that you will pay such amounts due for your care.

Patients Without Insurance

For patients without insurance coverage, you will be responsible for payment on the day of treatment. If you are not able to pay in full, or if your treatment requires several visits, you will be issued an invoice and will be able to discuss payment arrangements with a member of our business office staff.

Cancellation/No Show Policy/Reschedules

Our office requires at least 48 hours advance notice to cancel your appointment. *This does not include Friday-Sunday changes. Office hours are Monday-Thursday 9:00 AM-5:00 PM If you are needing to make changes to your appointment you must notify the office by: Monday Appt: Wednesday before 5pm Tuesday Appt: Thursday before 5pm Wednesday Appt: Monday before 5pm Thursday Appt: Tuesday before 5pm *We reserve the

right to charge a reasonable fee ($50), up to the amount normally due for our services, for patients who do not give advance notice to cancel an appointment.

By checking this box I acknowledge the following:

☐ I have read and understood the Cancellation/ No Show and Rescheduling Policy as stated above.

Collections

A charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on your account including all attorneys' fees, interest, and late fees.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature:

Sign

Consent for Use and Disclosure of Protected Health Information

SECTION A: PATIENT GIVING CONSENT

☐ Initial Acknowledgement of Privacy Practices

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to protected health information that we maintain.

Authorization to Disclose Protected Health Information

I hereby authorize Willow Family Dentistry, to disclose my protected health information to health care providers and the following below:

Names, Phone Numbers & Relationship for Authorization of individuals (If none: N/A):

Description of Information to be disclosed:

The information to be disclosed includes: Treatment History Full Dental Records (All documents, notes & x-rays requested) Billing & Account information

Checkboxes

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

Signature:

Sign

Signature and Acknowledgement

I hereby acknowledge that I have read and understand the contents of this authorization form. I consent to the release of my dental health information as described above in accordance with the provisions of HIPAA. I understand that I may ask for clarification of this authorization or additional information if necessary.

Signature

Sign

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:

Relationship to Patient:

Dental Insurance

Subscriber First Name:

Subsriber Last Name:

Subscriber DOB:

SS#:

Relationship to Policy Holder:

Employer:

Insurance Company Name:

Phone #:

Subscriber ID:

Group #:

Insurance Card - Front

No File Uploaded

Insurance Card -Back

No File Uploaded

Driver License/ID Front

No File Uploaded

Driver License/ID Back

No File Uploaded

Signature of Patient, Parent, Guardian or Personal Representative:

Sign

Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient: