PLEASE PRINT

Patient Information

Child's Name: _____ □ Male □Female
Last First Middle

Nickname: _____ School: _____ Grade: _____

Address: _____
Street City State Zip

Home Phone: _____ Birth date: ____/___/_____ Age: _____

Whom may we thank for referring you to our office? _____

Parent/Legal Guardian Information

Parent's Marital Status: □ Single Married □ Divorced □ Other

□ **Father** □Stepfather □ Legal Guardian

Name: _____

Birth date: ____/___/_____

Mailing Address: (If different than Child's)

_____
Street City State Zip

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Email Address: _____

Mother □ Stepmother □ Legal Guardian

Name: _____

Birth date: ____/___/_____

Mailing Address: (If different than Child's)

_____
Street City State Zip

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer: _____

Email Address: _____

Insurance Information

Primary Insurance Information:

Subscriber's Name: _____ Subscriber's Birth date: ____/___/_____

Subscriber's Social Security #: _____ Subscriber's ID#: _____

Subscriber's Employer: _____ Group/Plan #: _____

Insurance Company Name: _____ Insurance Company Phone #: _____

Insurance Company Address: _____
Street City State Zip

Emergency Contact Information

Relative or friend not living with you:

Name: _____ Phone #: _____

Address: _____
Street City State Zip

Relationship to child: _____

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Pediatric Dentistry

Health History Information

Name of child's pediatrician: _____ Phone #: _____
Name of child's previous dentist: _____ Phone #: _____
Date of last dental visit: _____

1. Does your child have previous dental experience? ----------	□Yes	□No	**Doctor's Notes**
2. If yes, was it pleasant? ----------	□Yes	□No	
3. Has your physician ever told you that your child needs an antibiotic before having any dental work?	□Yes	□No	
4. Is the child under a physician's care? ----------	□Yes	□No	
If yes, why? _____			
5. When was the child's last physical exam? _____			
6. Is the child taking any medications or substances? ----------	□Yes	□No	
If yes, please list. _____			
7. Is the child allergic to any medication or substances? ----------			
If yes, please list. _____	□Yes	□No	
8. Does the child have any problems with penicillin, antibiotics, local anesthetics or other types or medications? List others: _____	□Yes	□No	
9. Is the child sensitive to any □ metals or □ latex? ----------	□Yes	□No	
If yes, what types? _____			
10. Has the child ever been treated for heart disease? ----------	□Yes	□No	
11. Does the child have a heart murmur? ----------	□Yes	□No	
12. Does the child have a pacemaker or an artificial heart valve implant? ----------	□Yes	□No	
13. Has the child ever had rheumatic fever? ----------	□Yes	□No	
14. Is the child pregnant or suspect that the child is pregnant? ----------	□Yes	□No	
15. Does the child take birth control medications? ----------	□Yes	□No	
16. Does the child have high blood pressure? ----------	□Yes	□No	
17. Has the child ever had a serious illness or surgery? ----------	□Yes	□No	
If yes, what? _____			
18. Has the child ever had □ radiation treatment or □ chemotherapy? ----------	□Yes	□No	
19. Does the child have □ soreness, □ clicking, or □ popping in the jaw joint? ----------	□Yes	□No	
20. Does the child have any blood disorders, such as □ anemia, □ leukemia, □ hemophilia, etc? --------	□Yes	□No	
21. Does the child have any artificial joints/prosthesis? ----------	□Yes	□No	
22. Has the child ever bled excessively after being cut or injured? ----------	□Yes	□No	
23. Has the child ever received a blood transfusion? ----------	□Yes	□No	
24. Does the child have any kidney, stomach, or liver problems? ----------	□Yes	□No	
25. Does the child have autism or any type of syndrome? ----------	□Yes	□No	
If any other syndrome, what type? _____			
26. Is the child developmentally delayed? ----------	□Yes	□No	
27. Is the child diabetic? ----------	□Yes	□No	
28. Does the child have asthma? ----------	□Yes	□No	
29. Is the child HIV positive or have AIDS? ----------	□Yes	□No	
30. Does the child have □ epilepsy or seizure disorders? ----------	□Yes	□No	
31. Has the child had or tested positive for hepatitis? ----------	□Yes	□No	
32. Did you read this question? ----------	□Yes	□No	

I certify that I have read and understand the foregoing questions, and hereby certify that the information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status.

Patient/Guardian Signature_____ Date_____

Appointments and Cancellations

When we make your appointment, we are reserving this particular time specifically for your child's needs. We are a highly specialized pediatric dental practice that requires adequate time with your child. We ask that you place **all effort** possible in making your child's appointment. If you must cancel an appointment, please give us at least a **48 hour** notice. This courtesy makes it possible to give your reserved time to another patient who would like it.

There is a *$100.00* charge for missed appointments and cancellations less than 24 hours. Each failed and no show appointment is documented in your child's chart. Repeated cancellations or missed appointments will result in loss of future appointment privileges and dismissal from the clinic. Furthermore, we have an obligation to report missed and failed appointments to the Illinois Department of Family Health which may result in termination of dental benefits. Future appointments cannot be scheduled until the missed/no show fee is paid in full.

We feel that our patient's time is valuable. When your appointment is made, we place all effort in preparing in advance for it. Except for emergency treatment, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

PRIVACY PRACTICES CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 healthcare providers who may involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above address to obtain a 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 healthcare 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. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

FINANCIAL POLICY FOR PRIVATE PATIENTS

We are dedicated to providing our patients with the best treatment available and base our treatment recommendation on what will be best for your child and not what your insurance company does or does not pay for. As a courtesy, our office will be happy to submit any insurance claims for your child. Your dental insurance is a contract between you, your employer, and your insurance company; therefore, you are ultimately responsible for your insurance coverage. Any co-pays, deductibles, or known percentages for your child's dental care must be paid the day services are rendered. **However, please remember that in most cases these figures are only estimates. We cannot guarantee what your insurance will pay. You will be responsible for any services not covered or paid by your insurance carrier.** Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we expect your insurance coverage to be, and your estimated out-of-pocket portion. This is only an estimate based upon generalized information provided by your dental insurance. We will be happy to submit for a pre-treatment estimate to your insurance company for any treatment. We ask that you contact us immediately after making any changes to your dental coverage, so that we may keep accurate and current records of your account and to expedite reimbursement of your dental benefits. We allow a maximum of 60 days for your insurance company to clear account balances. After 60 days, any unpaid portions will be due in full by you. For your convenience, we accept cash, money orders, cashier's checks, and credit cards. I acknowledge that I have read, understand, and am willing to comply with the above financial policy.

Signature of Parent or Legal Guardian: _____ **Date:** _____