Welcome

1 About Your Child

Today's Date: _____

Child's Name: _____
LAST FIRST MI

Child's Nickname: _____ ❑Boy ❑Girl

Child's Birthdate: _____ Age: _____

School: _____ Grade: _____

Child's Home Phone #: ( ) _____

Child's SS#: _____

Child's Address: _____

_____
CITY STATE ZIP

Referred by: _____
(IF DOCTOR, PLEASE GIVE ADDRESS AND PHONE NUMBER)

_____

2 Insurance Information

Primary Dental Insurance

Company Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: ( ) _____

Insured's SS#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: _____

Insured's Employer: _____

Secondary Dental Insurance

Company Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: ( ) _____

Insured's SS#: _____

Group # (Plan, Local or Policy#): _____

Insured's Name: _____

Relation: _____ Date of Birth: _____

Insured's Employer: _____

3 Child's Family Information

Who is accompanying this child today? _____

_____ _____
(FULL NAME IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑yes ❑ no

How many Brothers/Sisters? _____ Age (s) _____ _____ _____

Mother's Name: _____
❑STEPMOTHER ❑GUARDIAN

_____
(❑CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

( ) _____ ( ) _____
HOME PHONE # WORK PHONE # EXT.

_____ _____
MOTHER'S SOCIAL SECURITY # MOTHER'S DRIVER'S LICENSE #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
❑STEPFATHER ❑GUARDIAN

_____
(❑CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

( ) _____ ( ) _____
HOME PHONE # WORK PHONE # EXT.

_____ _____
FATHER'S SOCIAL SECURITY # FATHER'S DRIVER'S LICENSE #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: _____ _____
RELATION TO CHILD

Billing Address: _____ Phone #: ( ) _____

_____
CITY STATE ZIP

SS#: _____ Driver's License #: _____

Employer: _____

Address: _____

_____
CITY STATE ZIP

Work Phone #: ( ) _____

Payment Method: ❑Cash ❑Check

❑Credit Card # (if accepted) _____

_____ I hereby authorize assigment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.
INITIALS

Please continue on next page

Page 2
Child's Name: _____

5 Child's Dental Information

Please indicate any of the following problems by checking the boxes below:

❑Discomfort, clicking or popping in jaw ❑Lost/Broken Filling (s) ❑Stained Teeth
❑Red, swollen or bleeding gums ❑Teeth Grinding ❑Locking Jaw
❑Sensitive tooth, teeth or gums ❑Ringing in Ears ❑Bad Breath
❑Blisters/sores in or around mouth ❑Broken/Chipped Tooth ❑Loose Tooth
❑Other (s): _____

Does Child require pre-medication? ❑Yes ❑ No ❑Don't know

Previous Dentist: _____ Phone #: ( ) _____

Last Dental Exam: _____ Last Dental X-rays: _____

Times a day Child brushes? _____ Times a week Child flosses? _____

Is the child's water fluoridated? ❑Yes ❑No

6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑Stimulants

❑Blood Thinners ❑Tranquilizers ❑Insulin ❑Muscle Relaxers ❑Others: _____

Child's Physician: _____ ( ) _____
DOCTOR'S NAME OR CLINIC NAME PHONE #

_____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures? Please circle below.

Y N Heart Murmur	Y N Tonsillitis	Y N High/Low Blood Pressure
Y N Rheumatic Fever	Y N Respiratory Problems	Y N Hepatitis
Y N Artificial Heart Valves	Y N Asthma/Difficulty Breathing	Y N Artificial Bones/Joints/Implants
Y N Congenital Heart Defect	Y N Blood Transfusion (s)	Y N Organ Problems
Y N Scarlet Fever	Y N Leukemia	Y N HIV+/AIDS/ARC
Y N Surgeries/Operations	Y N Anemia	Y N Tuberculosis TB
Y N Cancer/Tumors	Y N Diabetes/Hypoglycemia	Y N Psychiatric Problems
Y N Chemotherapy	Y N Hemophilia	Y N Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	Y N Abnormal Bleeding	Y N Fainting/Seizures/Epilepsy

Please list any other medical condition (s) Child has or ever had: _____

Is Child allergic to any of the following? ❑Latex ❑Penicillin/Amoxicillin ❑Tetracycline ❑Aspirin ❑Food allergies ❑Dental Anesthetics

❑Other (s): _____

Please rate the Child's general health from (worst) 1-10 (best): _____ Does Child wear contact lenses? ❑Yes ❑No

Has this Child ever taken the drug Ritalin?❑ No ❑Yes/How long? _____

Does this Child do any of the following? ❑Thumb/Finger Sucking ❑Tongue Thrusting/Sucking ❑Heavy Snoring
❑Mouth Breathing ❑Lip Sucking/Biting

Has the Child ever responded adversely to medical or dental treatment? _____

Is the Child under a physician's care now? _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my Child's account for any professional services rendered. I have read all the information on both sheets and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my Child's status or the above.

Thank you for considering our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and/or assist you in any way we can.

Signature _____ Date _____

Parent (if minor) _____ Date _____

NAME OF OFFICE: _____

Arbor Dental
2 Walter Scholer Dr. Lafayette, IN 47909
765. 477. 6100
info@arbor.dental

CONTACT INFORMATION FOR PROTECTED HEALTH INFORMATION

I, _____, Date of Birth: _____, request that the following be followed for the disclosure of my Protected Health Information. Protected Health Information would include your name, diagnosis(es), tests results, dates of service.

PLEASE CHECK ALL THAT APPLY

☐ You may disclose information to my family members and or non-family members. Please list name, phone number, and relationship.

Name	Phone Number	Relationship

☐ You may leave Protected Health Information on my answering machine/voicemail.

Phone Number: _____

☐ Other: _____

You may disclose insurance information to a referring dental office.

Patient's Signature: _____ Date: _____

_____ _____

Patient's Printed Name

_____ _____

Patient's Signature (or Guardian, if minor) Date

_____ _____

Witness (optional) Date

PATIENT CONSENT FORM

Arbor Dental
2 Walter Scholer Dr. Lafayette, IN 47909
765. 477. 6100
info@arbor.dental

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 be 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 you of 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 address below 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 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.

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.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

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