Patient Information for a Minor Patient

Today's date: _____

Patient name (first, MI, last)**:** _____

Patient's nickname: _____

Patient's primary residency: ☐ Both parents ☐ Mother ☐ Father ☐ Stepparent ☐ Shared custody ☐ Guardian

Address (street, city, state, ZIP)**:** _____

Home phone: _____ **Gender:** ☐ Male ☐ Female

Date of birth: _____ **Age:** _____

School: _____ **Hobbies/sports:** _____

Names and ages of other children in your family: _____

Parent / Guardian Information

Name of responsible party (first, MI, last)**:** _____

Date of birth: _____ **Relationship to patient:** _____

Address (if different from patient)**,** (street, city, state, ZIP)**:** _____

Home phone: _____ **Work phone:** _____

Mobile phone: _____ **E-mail:** _____

By providing your e-mail address you agree to receive (check one or both)**:** ☐ Appointment reminders ☐ Practice newsletter

Employer: _____ **Occupation:** _____ **Work phone:** _____

Work address (street, city, state, ZIP)**:** _____

Name of financially responsible party, (if different from above)**,** (first, MI, last)**:** _____

Is financially responsible party the same as legal guardian? ☐

Date of birth: _____ **Relationship to patient** (mother, father or other)**:** _____

Address (if different from patient)**,** (street, city, state, ZIP)**:** _____

Employer: _____ **Occupation:** _____ **Work phone:** _____

Work address (street, city, state, ZIP)**:** _____

Dental Benefit Plan Information

Primary dental plan name: _____

Address (street, city, state, ZIP)**:** _____

Name of insured: _____ **Date of birth:** _____

ID number: _____ **Policy number:** _____

Patient relationship to insured: _____

Secondary dental plan name: _____

Address (street, city, state, ZIP)**:** _____

Name of insured: _____ **Date of birth:** _____

ID number: _____ **Policy number:** _____

Patient relationship to insured: _____

Medical Plan Information

Plan name: _____

Address (street, city, state, ZIP)**:** _____

Name of insured: _____ **Date of birth:** _____

ID number: _____ **Policy number:** _____

Patient relationship to insured: _____

Authorizations for Responsible Party Form

We are committed to providing you and your child with the best possible care. Toward this goal, we would like to explain your financial and scheduling responsibilities with our practice.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment:

_____.

Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help the parents and guardians of our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this and you will be responsible for the difference.

If we are not a contracted provider with your dental benefit plan, it is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $150.00 or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of $150.00 or deposit to reserve the appointment time again, may be required.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that my child may need and have consented to during diagnosis and treatment. (initial) _____

I have read the above and agree to the financial and scheduling terms. (initial) _____

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. (Circle One) (initial) _____

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. (initial) _____

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. (initial) _____

Signature of responsible party: _____ Date: _____

Confidential Medical & Dental History for a Minor Patient

Today's Date: _____

Patient Name (first, MI, last): _____ Date of birth: _____

Medical History *(Please circle Yes or No for each)*

1. Physician's name: _____ Physician's phone: _____

2. Date of last medical examination? _____ Weight: _____

3. Patient is in good health? [ ] **If no, why?** _____

4. Patient has regular medical exams? [ ]

5. Patient is under the care of a physician at this time? [ ] **If yes, why?** _____

6. Patient is up to date with immunizations? [ ]

7. Patient is presently taking medications? [ ] **If yes, what and why?** _____

8. Patient has allergies (medications, food, latex/rubber)**?** [ ] **If yes, what?** _____

9. Patient has been hospitalized? [ ] **If yes, why and when?** _____

10. Patient has had any operations? [ ] **If yes, why and when?** _____

11. Patient has had general anesthesia? [ ]

12. If yes, were there any complications? [ ] **If yes, please explain complications:** _____

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

[ ]	Anemia	[ ]	Heart defects
[ ]	Arthritis, rheumatism	[ ]	Heart disease /defects / murmurs
[ ]	Artificial prosthesis, organs, joints, implants, shunts, valves	[ ]	Hepatitis
[ ]	Asthma	[ ]	High blood pressure
[ ]	Blood disorder	[ ]	Jaundice
[ ]	Blurred vision	[ ]	Joint pain or stiffness
[ ]	Bone pain	[ ]	Kidney or bladder disease
[ ]	Canker or cold sores	[ ]	Muscle pain, weakness
[ ]	Chest pain, tightness, wheezing	[ ]	Persistent cough or runny nose
[ ]	Diabetes	[ ]	Recent significant weight loss
[ ]	Diarrhea or constipation	[ ]	Rheumatic fever
[ ]	Ear infections	[ ]	Seizures
[ ]	Eating disorders	[ ]	Sexual transmitted disease
[ ]	Excessive thirst	[ ]	Shortness of breath
[ ]	Eye disease	[ ]	Skin disease
[ ]	Fainting spells	[ ]	Spina bifida
[ ]	Family history of diabetes	[ ]	Stomach problems or ulcers
[ ]	Fever	[ ]	Stroke
[ ]	Frequent urination	[ ]	Thyroid disease
[ ]	Frequent vomiting	[ ]	Transplants
[ ]	Headaches	[ ]	Tuberculosis
[ ]	Hearing problems, ear pain	[ ]	Tumors or cancer
[ ]	Heart attack	[ ]	Urinary tract Infections

This information will not be released unless specifically authorized by patient.

[ ]	Treatment for emotional, mental, or physical delays	[ ]	Anxiety
[ ]	AIDS/HIV	[ ]	Depression

13. Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? [ ]

14. If yes, explain: _____

15. Is there any issue or condition that you would like to discuss with the dentist in private? [ ]

(dental history continued on next page)

Dental Health History

16. Is this the patient's first dental visit? ▽ **Please list the reason for the visit:** _____

17. Date of last dental examination: _____

18. Name of patient's previous dentist: _____

19. Reason(s) for leaving the patient's previous dentist: _____

20. Date of last dental radiographs (X-rays): _____

21. Does the patient respond well to his/her pediatrician or past dentist: ▽ **If no, please explain:** _____

Has the patient experienced, have or had any of the following? *(Please circle Yes or No for each)*

▽	Injuries to the face, mouth, or teeth	▽	Habits (cheek biting, lip biting/sucking, tongue thrusting)?
▽	Thumb, finger, or pacifier sucking? Until what age:	▽	Speech Problems?
▽	Missing or extra permanent teeth?	▽	Habit of going to bed with a bottle?
▽	Mouth breathing, snoring, enlarged adenoids or tonsils?	▽	Jaw pain, clenching or grinding of teeth?

22. Do you live in a community with fluoridated water? ▽ ☐ Do not know

23. Does the patient drink tap water? ▽

24. Does the patient use any fluoride supplements (rinses, vitamins)? ▽ **If yes, name of product:** _____

25. How often does the patient brush his/her teeth? _____

26. Does the patient floss his/her teeth? ▽ **If yes, how often?** _____

27. Has the patient ever been evaluated for or had orthodontic treatment? ▽

28. If considering orthodontic treatment, what would you most like it to accomplish for the patient? _____

Authorizations

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact the patient's physician:

Responsible Party's Signature: _____ Date: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my child's dentist of any change in my child's health and/or medication. Further, I will not hold my child's dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Responsible Party Signature (Parent or Guardian): _____ Date: _____

Signature of Dentist: _____ Date: _____

I have reviewed my child's Health History and confirm that it accurately states past and present conditions.

Parent/Guardian Signature: _____ Date: _____

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

Date	Patient Signature	Changes to Health History	Dentist Initials

Authorization for a Care-Taker
(non-legal guardian) to Accompany a Minor to Appointments

Patient Name (first, MI, last)**:** _____

Patient Social Security Number: _____

I _____ (legal guardian name) authorize _____(name of care-taker) to bring my minor child _____ (child's name) to _____ (practice name) for scheduled appointments for treatment in which a legal guardian to my child has previously consented be performed on my child.

I understand this authorization for a care-taker to accompany my minor child to appointments does not permit the care-taker to consent to treatment on behalf of a legal guardian. I understand that only a legal guardian may consent to treatment for my child.

If treatment consent, that has not been previously diagnosed and accepted by a legal guardian authorized as such with this practice, is required at an appointment in which a care-taker is accompanying my minor child, the legal guardian will be contacted prior to proceeding with the treatment plan. If the legal guardian cannot be reached to provide treatment consent, the treatment will not be performed.

I understand that only a legal guardian may accompany my minor child to an appointment in which sedatives are scheduled to be administered, regardless of whether the sedation technique was previously consented to by a legal guardian authorized as such with this practice.

I understand that this authorization will remain in effect until the practice is otherwise notified of the above designated care-taker's change in status. I understand that it is my responsibility, as the legal guardian, to inform this practice of any change to this authorization.

Parent / Legal Guardian Signature: _____ Date: _____