

# WELCOME

## TELL US ABOUT YOUR CHILD

CHILD'S NAME: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_ SSN: \_\_\_\_\_  
PREFERRED NAME: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_ PHONE: \_\_\_\_\_  
HOME ADDRESS: \_\_\_\_\_ CITY, STATE, ZIP: \_\_\_\_\_  
PREVIOUS DENTIST: \_\_\_\_\_ LAST VISIT DATE: \_\_\_\_\_  
WHOM MAY WE THANK FOR REFERRING HIM/HER? \_\_\_\_\_

## WHO IS ACCOMPANYING THE CHILD TODAY?

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY CHILD ON THEIR INITIAL VISIT.  
DO YOU HAVE LEGAL CUSTODY OF THIS CHILD? YES NO  
IS THE CHILD ADOPTED? YES NO

THE PARENT OR GUARDIAN WHO BRINGS THE CHILD FOR THEIR VISIT IS RESPONSIBLE FOR PAYMENT INDEPENDENT OF WHAT A DIVORCE DECREE MAY STATE. REIMBURSEMENT MUST BE MADE BETWEEN THE DIVORCED PARENTS. WE WILL NOT INTERVENE.

## MOTHER

NAME: \_\_\_\_\_  
SSN: \_\_\_\_\_  
DRIVER'S LICENSE: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_  
PREFERRED NUMBER YOU WOULD  
LIKE US TO USE: \_\_\_\_\_

## FATHER

NAME: \_\_\_\_\_  
SSN: \_\_\_\_\_  
DRIVER'S LICENSE: \_\_\_\_\_  
BIRTHDATE: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_  
EMAIL ADDRESS: \_\_\_\_\_  
HOME PHONE: \_\_\_\_\_  
CELL PHONE: \_\_\_\_\_  
WORK PHONE: \_\_\_\_\_  
PREFERRED NUMBER YOU WOULD  
LIKE US TO USE: \_\_\_\_\_

## INSURANCE INFORMATION

DENTAL COVERAGE:  YES  NO INSURANCE COMPANY: \_\_\_\_\_  
INSURANCE CO. PHONE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_  
POLICY OWNER'S NAME: \_\_\_\_\_ RELATIONSHIP TO PATIENT: \_\_\_\_\_  
GROUP NUMBER: \_\_\_\_\_ SSN/ID NUMBER: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED AT THE TIME OF SERVICE AND ALSO RESPONSIBLE FOR PAYING ANY CO-PAYMENT AND DEDUCTIBLE THAT MY INSURANCE DOES NOT COVER AT TIME OF SERVICE. I REALIZE FAILURE TO KEEP THIS ACCOUNT CURRENT MAY RESULT IN YOU BEING UNABLE TO PROVIDE ADDITIONAL DENTAL SERVICES EXCEPT FOR DENTAL EMERGENCIES OR WHERE THERE IS PREPAYMENT FOR ADDITIONAL COSTS AND REASONABLE ATTORNEY FEES INCURRED IN ATTEMPTING TO COLLECT ON THIS AMOUNT OR ANY FUTURE OUTSTANDING BALANCES.

I AFFIRM THAT THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. IT WILL BE HELD IN THE STRICTEST CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

## Dental History

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

What is the purpose of your visit today? \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Date of last dental care: \_\_\_\_\_

Has your child experienced any problems associated with previous dental work? If yes, please explain: \_\_\_\_\_

How often does your child brush? \_\_\_\_\_ Floss? \_\_\_\_\_

Is his/her teeth sensitive to heat, cold or anything else? \_\_\_\_\_

Is the child's water fluoridated?    Yes    No    Not Sure

Has your child been informed of any missing or extra permanent teeth?    Yes    No

Have there been any injuries to the face, mouth, teeth or chin?    Yes    No    If yes, please explain: \_\_\_\_\_

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ / TMD)?    Yes    No

## Medical History

Child's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

Are your child's immunizations current?    Yes    No

Please list all drugs that your child is currently taking: \_\_\_\_\_

Please list all drugs and foods that cause your child's allergic reactions: \_\_\_\_\_

### Check if your child has experienced any of the following medical problems:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Liver Problems     |
| <input type="checkbox"/> ADD/ADHD                | <input type="checkbox"/> Exposed to HIV, but Neg. | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Food Color Allergy       | <input type="checkbox"/> Measles            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Handicaps / Disabilities | <input type="checkbox"/> Mononucleosis      |
| <input type="checkbox"/> Any Hospital Stays      | <input type="checkbox"/> Hearing Impairment       | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Any Operations          | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Seizure Disorder   |
| <input type="checkbox"/> Autism                  | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Sensory Disorder   |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Skin Rash          |
| <input type="checkbox"/> Chicken Pox             | <input type="checkbox"/> Hives                    | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> HIV+                     | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Convulsion              | <input type="checkbox"/> Kidney                   |   |

### Check if your child has had / has any of the following:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Lip Sucking / Biting | <input type="checkbox"/> Clenching / Grinding Teeth | <input type="checkbox"/> Tongue / Cheek Biting |
| <input type="checkbox"/> Nail Biting          | <input type="checkbox"/> Used Pacifier              | <input type="checkbox"/> Speech Problems       |
| <input type="checkbox"/> Chewing on Objects   | <input type="checkbox"/> Nursing Bottle Habits      | <input type="checkbox"/> Tongue Thrust         |
| <input type="checkbox"/> Mouth Breather       | <input type="checkbox"/> Thumb / Finger Sucking     | <input type="checkbox"/> Breast Fed            |

Please discuss any serious medical problems the child has or had in the past: \_\_\_\_\_

Anything you would like to discuss with the Doctor in private?    Yes    No    If yes, please explain: \_\_\_\_\_

I affirm that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest 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.

Signature of parent or guardian

Date

#### Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor's Comments: \_\_\_\_\_

Medical History Update

1. Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Comments: \_\_\_\_\_

2. Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Comments: \_\_\_\_\_

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient #: \_\_\_\_\_ Social Security #: \_\_\_\_\_

## 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 any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Linda Lindblad

Telephone: 972-491-3916 Fax: 972-491-7856

E-mail: \_\_\_\_\_

Address: 5800 Coit Rd Suite 600 Plano, Texas 75023

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## SIGNATURE

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: \_\_\_\_\_ Date: \_\_\_\_\_

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

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.**

**Include completed Consent in the patient's chart.**

**REVOCACTION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_