



WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

M F Age _____ Birthdate: _____ Hobbies: _____

Home Address: _____
Street Apartment #

_____ City State Zip Code

Person financially responsible _____ Phone (Home): _____ (Work): _____

Whom may we thank for referring you? _____

INSURANCE

Primary

Name of Insured: _____ Relationship to patient: _____
Last First MI

Insured's Address (if different than pt): _____

Insured's Employer Name: _____

Birth Date: _____ SS #: _____ Group # _____ Policy # _____

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Relationship to patient: _____
Last First MI

Insured's Address (if different than pt): _____

Insured's Employer Name: _____

Birth Date: _____ SS #: _____ Group # _____ Policy # _____

Insured's Employer Name: _____

Insurance Plan Name and Address: _____

DENTAL HISTORY

Date of last visit to dentist _____ For what service? _____

Has child complained about dental problems?..... yes no Is fluoride taken in any form?..... yes no

Does child brush teeth daily?..... Any injuries to mouth, teeth, head?.....

Does child use floss every day? Any unhappy dental experiences?.....

Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc ?

Minor / Child's Physician _____ City / State _____ Phone _____

Date of last physical examination _____ Results _____

Is Minor / Child under care of physician now?..... Medications _____

Receiving any medication or drugs?..... _____

Ever been hospitalized?..... _____

Ever had surgery?..... Allergies _____

Is there excessive bleeding when cut? _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> A.I.D.S./H.I.V | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of 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 for my minor / child.

Signature of Parent / Guardian

Date

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan Law requires us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review on entity's functions; a claim for payment of fee; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse / neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating you treatment.

Patient Acknowledgement

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient Signature (guardian signature for minor)

Patient Name

Date

Patient Consent

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Patient Signature (guardian signature for minor)

Patient Name

Date

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For office use:

Benefit year _____ Deductable: _____ met: y / n Preventative: _____

Yrly Maximum: _____ Used to date: _____ Basic: _____

Waiting period: _____ Major: _____

Perio therapy: _____ Occlusal guard: _____ COB _____