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? ☐ Yes ☐ No

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 $_____ 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 $_____ 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. YES / NO (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?** Yes / No **If no, why?** _____
4. **Patient has regular medical exams?** Yes / No
5. **Patient is under the care of a physician at this time?** Yes / No **If yes, why?** _____
6. **Patient is up to date with immunizations?** Yes / No
7. **Patient is presently taking medications?** Yes / No **If yes, what and why?** _____
8. **Patient has allergies** (medications, food, latex/rubber)? Yes / No **If yes, what?** _____
9. **Patient has been hospitalized?** Yes / No **If yes, why and when?** _____
10. **Patient has had any operations?** Yes / No **If yes, why and when?** _____
11. **Patient has had general anesthesia?** Yes / No
12. **If yes, were there any complications?** Yes / No **If yes, please explain complications:** _____

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

Yes / No	Anemia	Yes / No	Heart defects
Yes / No	Arthritis, rheumatism	Yes / No	Heart disease /defects / murmurs
Yes / No	Artificial prosthesis, organs, joints, implants, shunts, valves	Yes / No	Hepatitis
Yes / No	Asthma	Yes / No	High blood pressure
Yes / No	Blood disorder	Yes / No	Jaundice
Yes / No	Blurred vision	Yes / No	Joint pain or stiffness
Yes / No	Bone pain	Yes / No	Kidney or bladder disease
Yes / No	Canker or cold sores	Yes / No	Muscle pain, weakness
Yes / No	Chest pain, tightness, wheezing	Yes / No	Persistent cough or runny nose
Yes / No	Diabetes	Yes / No	Recent significant weight loss
Yes / No	Diarrhea or constipation	Yes / No	Rheumatic fever
Yes / No	Ear infections	Yes / No	Seizures
Yes / No	Eating disorders	Yes / No	Sexual transmitted disease
Yes / No	Excessive thirst	Yes / No	Shortness of breath
Yes / No	Eye disease	Yes / No	Skin disease
Yes / No	Fainting spells	Yes / No	Spina bifida
Yes / No	Family history of diabetes	Yes / No	Stomach problems or ulcers
Yes / No	Fever	Yes / No	Stroke
Yes / No	Frequent urination	Yes / No	Thyroid disease
Yes / No	Frequent vomiting	Yes / No	Transplants
Yes / No	Headaches	Yes / No	Tuberculosis
Yes / No	Hearing problems, ear pain	Yes / No	Tumors or cancer
Yes / No	Heart attack	Yes / No	Urinary tract Infections

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

Yes / No	Treatment for emotional, mental, or physical delays	Yes / No	Anxiety
Yes / No	AIDS/HIV	Yes / No	Depression

13. **Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form?** Yes / No
14. **If yes, explain:** _____
15. **Is there any issue or condition that you would like to discuss with the dentist in private?** Yes / No

(dental history continued on next page)

Dental Health History

16. **Is this the patient's first dental visit?** Yes / No **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:** Yes / No **If no, please explain:** _____

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

Yes / No	Injuries to the face, mouth, or teeth	Yes / No	Habits (cheek biting, lip biting/sucking, tongue thrusting)?
Yes / No	Thumb, finger, or pacifier sucking? Until what age:	Yes / No	Speech Problems?
Yes / No	Missing or extra permanent teeth?	Yes / No	Habit of going to bed with a bottle?
Yes / No	Mouth breathing, snoring, enlarged adenoids or tonsils?	Yes / No	Jaw pain, clenching or grinding of teeth?

22. **Do you live in a community with fluoridated water?** Yes / No ☐ Do not know

23. **Does the patient drink tap water?** Yes / No

24. **Does the patient use any fluoride supplements (rinses, vitamins)?** Yes / No **If yes, name of product:** _____

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

26. **Does the patient floss his/her teeth?** Yes / No **If yes, how often?** _____

27. **Has the patient ever been evaluated for or had orthodontic treatment?** Yes / No

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