Patient Information for a Minor Patient Today's date: __ Patient name (first, MI, last): Patient's nickname: ☐ Guardian ☐ Father ☐ Stepparent ☐ Shared custody □Mother Patient's primary residency: Both parents Address (street, city, state, ZIP): Home phone: _____ Gender: Dender Female Date of birth: ______ Age: ____ Hobbies/sports: School: Names and ages of other children in your family: __ Parent / Guardian Information Name of responsible party (first, MI, last): Relationship to patient: Date of birth: 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 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? $\ \square$ Yes $\ \square$ 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): Date of birth: Name of insured: Policy number: ID number: Patient relationship to insured: Secondary dental plan name: Address (street, city, state, ZIP): ___Date of birth: _____ Name of insured: Policy number:_____ ID number: Patient relationship to insured: **Medical Plan Information** Plan name: Address (street, city, state, ZIP): Name of insured: ______Date of birth: ______ Policy number:____ ID 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.				ty knobster	Tarking a ven

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.

Signature of responsible party:

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	out being on-time.
Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able	
maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48	
\$ or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely m	
to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an ap	
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) ______

Date:

Confidential Medical & Dental History for a Minor Patient

Patient Name (first), Mi, last): Medical History (Plaose circle Yes or No for each) 1. Physician's name: 2. Date of last medical examination? 3. Potient is in good health? Yes / No If no, why? 4. Potient has regular medical examination? 5. Patient is greatly medical examination? 6. Patient is up to date with immunizations? Yes / No 6. Patient is up to date with immunizations? Yes / No If yes, why? 8. Patient has been hospitalized? Yes / No If yes, whot and why? 8. Patient has been hospitalized? Yes / No If yes, why and when? 10. Patient has had general anesthesia? Yes / No If yes, why and when? 11. Patient has had general onesthesia? Yes / No If yes, why and when? 11. Patient has had general onesthesia? Yes / No If yes, please explain complications: 11. Fatient has had general onesthesia? Yes / No If yes, please explain complications: 12. If yes, were there any complications? Yes / No If yes, please explain complications: 13. If yes, were there any complications? Yes / No If yes, please explain complications: 14. If yes, were there any complications? Yes / No If yes, please explain complications: 15. If yes, were there any complications? Yes / No If yes, please explain complications: 16. Ves / No Anemia Yes / No Heart defects Yes / No Heart defects Yes / No Anemia Yes / No Heart defects Yes / No Heart defects Yes / No Anemia Yes / No Heart defects Yes / No Heart defects Yes / No Anemia Yes / No Heart defects Yes / No Joundice Yes / No Heart defects Yes / No Heart defects Yes / No Heart defec	Today's Da	te:		modernments leaves to 4 to 45
Medical History (Please circle Yes or No for each) 1. Physician's name: 2. Date of lost medical examination? 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 8. Patient is up to date with immunizations? Yes / No 8. Patient has beginned in the care of a physician at this time? 9. Patient has been hospitalized? Yes / No 16. Patient has been hospitalized? Yes / No 17. Patient has been hospitalized? Yes / No 18. Patient has been hospitalized? Yes / No 19. Patient has bed any operations? Yes / No 19. Patient has bed any operations? Yes / No 19. Patient has had any operations? Yes / No 19. Patient has had any operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Patient has had ony operations? Yes / No 19. Atthitis, rheumatism 19. Yes / No 20. Atthitis, rheumatism 29. Atthitis, rheumatism 29. Yes / No 29. Atthitis, rheumatism 29. Atthitis, rheumatism 29. Yes / No 29. No 29. Atthitis, rheumatism 29. Yes / No 29. No 29. Atthitis, rheumatism 29. Yes / No 29. No 29. Atthitis, rheumatism 29. Yes / No 29.	Patient Nar	ne (first, MI, last):		Date of hirth
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Yes / No Chest pain, tightness, wheezing Yes / No Recent significant weight loss Yes / No Diabetes Yes / No Recent significant weight loss Yes / No Diarrhea or constipation Yes / No Recent significant weight loss 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 Shortness of breath Yes / No Family history of diabetes Yes / No Stomach problems or ulcers Yes / No Family history of diabetes 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 Information will not be released unless specifically authorized by patient. Yes / No Anxiety Yes / No Depression Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? Yes / No If yes, explain:				
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l. If yes, explain:				
			dical probler	ns NOT listed on this form? Yes / No

Dental Health	n History		
16. Is this the	patient's first dental visit? Yes / No Please list the rea	son for the	visit:
17. Date of la	ıst dental examination:		
	patient's previous dentist:		
19. Reason(s)	for leaving the patient's previous dentist:		THE PARTY OF THE P
	ast dental radiographs (X-rays):		
21. Does the	patient respond well to his/her pediatrician or past denti	st: Yes/N	o If no, please explain:
Has the patie	ent experienced, have or had any of the following? (Pleas	e 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?
		□ Do not kr	now
23. Does the	patient drink tap water? Yes / No	V (N)	cki to in Specialisana is revery and and make?
24. Does the	patient use any fluoride supplements (rinses, vitamins)?	Yes / No	If yes, name of product:
	en does the patient brush his/her teeth?		abban ban in also result on mary framework as a consistence of
	patient floss his/her teeth? Yes / No If yes, how often		No
	patient ever been evaluated for or had orthodontic treatm ering orthodontic treatment, what would you most like it t		
Zo. Il Collside	ering ormodoline freditient, what would you most like it i	o accomplis	in for the punetiti
Authorization	ns of dentistry involves treating the whole person. If the dentist o	datarminas t	pet there may be a potentially medically compromised
	dical consultation may be needed prior to commencement of		
	ne dentist to contact the patient's physician:		
	Party's Signature:		Date:
accurately. I	I have read and understand this form. To the best of my will inform my child's dentist of any change in my child's member of his/her staff, responsible for any errors or on	health and/	or medication. Further, I will not hold my child's dentis
	Party Signature (Parent or Guardian):		
Signature of			Date:
	ved my child's Health History and confirm that it accurate	ly states pas	st and present conditions.
	dian Signature:		Date:
Medical Upd	oración de la		Appropried to the set of the last the set of
	wed my Health History and confirm that it accurately state	es past and p	present conditions.
Date	Patient Signature	Changes to	Health History Dentist Initials
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