MEDICAL HISTORY

Child's Name: _____

Y N

- ☐ ☐ Allergies _____
- ☐ ☐ Anemia
- ☐ ☐ Asthma
- ☐ ☐ Bleeding
- ☐ ☐ Heart Murmur
- ☐ ☐ Seizures
- ☐ ☐ Was pregnancy less than full term?
- ☐ ☐ Hospitalized since birth?
- ☐ ☐ Are you taking any medications, **INCLUDING OTC**? _____
- ☐ ☐ Any medical conditions not stated above that should be brought to our attention:

_____

_____

DENTAL HISTORY

Reasons for today's visit: _____

- ☐ ☐ Do you have any concerns you would like to talk to the dentist about today?
- ☐ ☐ Is this your first dental visit? If no, when was the last visit and where? _____
- ☐ ☐ Has your child ever had a reaction to dental anesthetic?
- ☐ ☐ Do you have a home water filtration system? If yes, what type? _____
- ☐ ☐ Any previous trauma to teeth? _____
- ☐ ☐ Are you under the care of an orthodontist? If yes, who? _____
- ☐ ☐ Is you child in need of any immunizations?
- ☐ ☐ Has child had trouble with previous dental care?
- ☐ ☐ Does your child have pain in his/her jaw joint?
- ☐ ☐ Is child experiencing any pain in his/her mouth/teeth? _____
- ☐ ☐ Does your child have bad breath?
- ☐ ☐ Nail biting, thumb sucking, pacifier or lip sucking/biting habits?
- ☐ ☐ Is your child a mouth breather?
- ☐ ☐ Clenching or grinding of teeth?
- ☐ ☐ Frequent bottle use/ sleeps with a bottle at night?
- ☐ ☐ Missing or extra teeth?
- ☐ ☐ How often does child brush/ floss? _____

Signature of Parent/ Guardian: _____

Printed Name: _____

Date: _____

New Patient Paperwork

Today's Date: _____

Please check box next to names of siblings who have been seen here before

Full Names of Patients (& Siblings)	Nickname
❑ _____	_____
Birthdate: _____ **Age:** _____	**Gender (circle):** M/F
❑ _____	_____
Birthdate: _____ **Age:** _____	**Gender (circle):** M/F
❑ _____	_____
Birthdate: _____ **Age:** _____	**Gender (circle):** M/F
❑ _____	_____
Birthdate: _____ **Age:** _____	**Gender (circle):** M/F
❑ _____	_____
Birthdate: _____ **Age:** _____	**Gender (circle):** M/F

Child/Children's Physician: _____

Physician's Phone number(s): _____

Name of Primary Dental Insurance: _____

****** How did you hear about our office:** _____

Mother's Name or Legal Guardian: _____

Address: _____ City: _____ State: _____ Zip code: _____

Email address: _____

(needed for appointment confirmations and office news that is emailed out from time to time)

Home phone: _____ Cell: _____ Work: _____

Employer: _____

Best phone number for appointment confirmations: _____ (CELL / HOME)

Father's Name or Legal Guardian: _____

Address SAME AS ABOVE? Y / N If yes, skip address . . .

Address: _____ City: _____ State: _____ Zip code: _____

Email address: _____

Home phone: _____ Cell: _____ Work: _____

Employer: _____

Best phone number for appointment confirmations: _____ (CELL / HOME)

OTHER (Step-Parent, Grandparent, etc): _____

Address SAME AS ABOVE? Y / N If yes, skip address . . .

Address: _____ City: _____ State: _____ Zip code: _____

Email address: _____

Home phone: _____ Cell: _____ Work: _____

Employer: _____

Best phone number for appointment confirmations: _____ (CELL / HOME)

Who is accompanying your child/children today: _____ Relationship: _____

CONSENT:

I give consent to Dr. Patty Schnur of Parrish Children's Dentistry to do a complete and thorough examination on my child, including any diagnostic radiographs, prophylaxis, and fluoride, and other preventative care that may be needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Dr. Patty of any future changes to my child's medical status. I authorize Dr. Patty to treat my child, using restorative and patient management techniques that are acceptable and proper. I understand that a treatment plan with associated fees will be discussed fully with me prior to the beginning of any treatment. I also understand that the treatment plan and fees could change depending on the time elapsed since the initial examination. In addition, I authorize release of this information to the patients' medical doctor of record and any other dental professionals that will be involved in his/her treatment.

As the parent or legal guardian, I do hereby grant Dr. Patty and her staff permission to perform any needed treatments. I understand that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

Signature: _____ Relationship: _____

INSURANCE:

Requirements for filing to insurance:

I do hereby give permission and authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within 30-days of treatment. I hereby authorize payment of insurance benefits directly to Parrish Children's Dentistry. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect this amount.

Signature: _____ Relationship: _____

SHARING CHILD'S INFORMATION: (You give permission to share child's information with person/s you list below)

I, _____ understand that by signing this, I am giving my consent to Parrish Children's Dentistry, to disclose and discuss my child's protected dental information to carry out treatment, payment activities and health care operations with the following *family member*.

Name: _____

Relationship: _____

Date: _____

You have the right to revoke this consent at any time by giving us written notice of your revocation.

****IMPORTANT NOTE****

PARRISH CHILDREN'S DENTISTRY CONFIRMS APPOINTMENTS BY PHONE, TEXT AND EMAIL. WE KINDLY ASK THAT YOU RESPOND WHEN YOU RECEIVE THESE MESSAGES. IF YOU WOULD LIKE TO DECLINE CONFIRMATIONS THROUGH ANY OF THESE METHODS, PLEASE LET US KNOW. WE ALSO SEND SURVEYS TO OUR PATIENTS AT TIMES TO MONITOR OUR PERFORMANCE. WE APPRECIATE YOUR FEEDBACK!

PLEASE UNDERSTAND THAT IF YOU HAVE TO RESCHEDULE OR CANCEL YOUR APPOINTMENT WITH ***LESS THAN A 48-HOUR NOTICE,*** IT WILL ADD A **$50 BROKEN APPOINTMENT FEE** TO EACH APPOINTMENT MISSED, OR A **$75 FEE** ON SCHOOL HOLIDAYS.

WE HAVE STAFF IN THE OFFICE MONDAY THRU FRIDAY. IF YOU DON'T REACH ANYONE OR YOUR CALL IS AFTER HOURS, YOU MAY LEAVE US A MESSAGE. OUR MESSAGES GIVE US THE DATE AND TIME OF YOUR CALL. IF IT IS TWO DAYS PRIOR TO YOUR CHILD'S APPOINTMENT, WE WILL COUNT THAT AS GIVING PROPER NOTICE!

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Permission to use PHOTO:

From time to time, we like to take pictures of our patients for winning office contests, having an amazing dental check-up with no cavities, a great "first" visit with us, dress up days, winning our no cavity club drawings, etc.

We would like your permission to use these photos on our Facebook page to share with all of our dental families. We will not use your child's first and last name together, at any time.

○ **If you wish to OPT OUT of this, please check this circle**. This will prevent your child from participating in the no cavity club, since our winners are posted on our Facebook page.

If this circle is NOT checked, please sign below – you are giving permission to use your child's photo for our contest fun!! Please feel free to ask if you have questions regarding this.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____

Parrish Children's Dentistry

HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act. (HIPAA) I understand that by signing this consent, I authorize you to use and disclose my entire medical record which contains protected health information to carry out:

- Treatment (Including direct or indirect treatment by other providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operation of your practice in accordance with your notice of privacy practices.

I have been informed of, and given the right to review and secure a copy of your notice of privacy practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with the restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____

Print Name: _____

Signature: _____

Relationship to Patient: _____