New Patient Packet

Date_____

Patient's name _____

Last First Middle

Address _____

Street City Zip

Nickname_____ Birthdate_____ Social Security # _____

School Currently Attending: _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name_____

Last First Middle

Residence _____

Street City Zip

Mailing Address_____

Street City Zip

How long at this address? _____ Home phone_____ Work phone_____

Cell/other phone_____ Email address_____

Social Security #_____ Birthdate_____ Relationship to Patient _____

Employer_____ Occupation_____ No. years employed _____

Spouse's Name_____ Relationship to Patient_____

Employer_____ Occupation_____ No. years employed _____

Social Security # _____ Birthdate _____Work Phone_____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Complete address_____

Street City Zip

Phone _____

MEDICAL INSURANCE INFORMATION

Policy Holder's Full Name_____ Policy Holder's Relation to Patient: _____

Insured's Social Security _____ Policy Holder's Date of Birth: _____

Policy Holder's Mailing Address: _____

Insurance Company_____ Group No._____ Subscriber ID No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Policy Holder's Full Name_____ Policy Holder's Relation to Patient: _____

Insured's Social Security _____ Policy Holder's Date of Birth: _____

Policy Holder's Mailing Address: _____

Insurance Company_____ Group No._____ Subscriber ID No. _____

Insurance Co. Address_____ Phone No._____

DENTAL INSURANCE INFORMATION

Policy Holder's Full Name_____ Policy Holder's Relation to Patient: _____

Insured's Social Security _____ Policy Holder's Date of Birth: _____

Policy Holder's Mailing Address: _____

Insurance Company_____ Group No._____ Subscriber ID No. _____

Insurance Co. Address_____ Phone No._____

Do you have dual coverage? Yes_____ No_____ If yes:

Policy Holder's Full Name_____ Policy Holder's Relation to Patient: _____

Insured's Social Security _____ Policy Holder's Date of Birth: _____

Policy Holder's Mailing Address: _____

Insurance Company_____ Group No._____ Subscriber ID No. _____

Insurance Co. Address_____ Phone No._____

HEALTH HISTORY

Patient Name:	Date of Birth:

Primary Care Physician (name and phone number):

Heart	☐ Heart Murmur ☐ Mitral Valve Prolapse ☐ Congenital Heart Defect ☐ Heart Surgery ☐ Low/High Blood Pressure ☐ Rheumatic Fever ☐ Other (not listed) ***Please Explain***: _____
Kidney	☐ Bladder ☐ Urinary Problems ☐ Other ***Please Explain***: _____
Liver / GI	☐ Reflux (GERD) ☐ Stomach/Intestine Ulcers ☐ Gastritis ☐ Colitis ☐ Diarrhea ☐ Jaundice ☐ Hepatitis ☐ Liver Disease ☐ Other (not listed) ***Please Explain***: _____
Endocrine	☐ Diabetes Type: _____ ☐ Thyroid Disease (Hyper/Hypo) ☐ Other (not listed) ***Please Explain***: _____
Hematologic	☐ Anemia ☐ Hemophilia ☐ Leukemia ☐ Sickle Cell Disease / Trait (circle) ☐ Prolonged Bleeding ☐ Blood Transfusion (latest date: _____ / Started: _____) ☐ Other (not listed) ***Please Explain***: _____
Lung / Respiratory	☐ Asthma ☐ Allergies/Hives ☐ Sinus Trouble ☐ Chronic Cough ☐ Hay Fever ☐ Tuberculosis ☐ Other ***Please Explain:*** _____
Neurological	☐ ADHD ☐ Autism ☐ Developmental Delay ☐ Speech Disorder ☐ Nervous Disorder ☐ Mental Disorder ☐ Down Syndrome ☐ Cerebral Palsy ☐ Seizures/Epilepsy ☐ Fainting ☐ Headaches ☐ Brain Injury ***Please Explain***: _____
Hearing / Vision	☐ Vision Problems ☐ Glaucoma ☐ Earaches ☐ Hearing Loss ☐ Other (not listed) ***Please Explain:*** _____
Dermal / Musculoskeletal	☐ Latex Allergy ☐ Eczema ☐ Rashes ☐ Fever Blisters/Cold Sores ☐ Other (not listed) ***Please Explain***: _____

Does your child have any disease, condition or other health problems not listed above? If yes, please explain:	☐ Yes ☐ No
Medications (names and dosages): Please list ALL taken, including vitamins & supplements	☐ Yes ☐ No
Does your child have any allergies to food or medications? If yes, please list:	☐ Yes ☐ No
Has your child been hospitalized overnight since birth? If yes, when? Why?	☐ Yes ☐ No
Has your child ever had any surgery? If yes, when? Why?	☐ Yes ☐ No
Has your child had any radiation or chemotherapy? If yes, when? Why?	☐ Yes ☐ No
Does your child use tobacco?	☐ Yes ☐ No
Does your child have AIDS or has he/she been tested HIV-positive?	☐ Yes ☐ No
Is your child adopted? If yes, does he/she know?	☐ Yes ☐ No
Females: any possibility of pregnancy?	☐ Yes ☐ No

Dental History

What is your primary concern about your child's oral health?

How would you describe:
your child's oral health? □ Excellent □ Good □ Fair □ Poor
your oral health? □ Excellent □ Good □ Fair □ Poor

How often does your child brush his/her teeth? _____ times per _____. Does someone help? □Yes □ No
How often does your child floss his/her teeth? _____ times per _____. Does someone help? □Yes □ No

Have there been any injuries to teeth, such as falls, blows, or accidents? When? Please describe: □Yes □ No
_____
_____

How frequently does your child have the following?
Candy or other sweets: □Rarely □1-2 times/day □3+ times/day Product _____
Chewing gum: □Rarely □1-2 times/day □3+ times/day Type _____
Snacks between meals: □Rarely □1-2 times/day □3+ times/day Usual snack _____
Soft drinks* □Rarely □1-2 times/day □3+ times/day Product _____
(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)
Please note other significant dietary habits: _____
_____

Has your child had any dental treatment completed in the past? When? _____ □Yes □ No
If yes, describe: _____

Has your child had any difficult dental experiences in the past? □Yes □ No
If yes, describe: _____

Does your child currently have any cavities? □Yes □ No

How do you expect your child will respond to dental treatment?
□ Very well □ Fairly well □ Somewhat poorly □ Very poorly

Is there any additional information that we should know before treating your child? □Yes □ No
If yes, describe:
_____
_____

_____ _____ _____ _____
PARENT/GUARDIAN SIGNATURE **PRINTED NAME** **(RELATIONSHIP TO PATIENT)** **DATE**

FINANCIAL POLICIES AND AGREEMENT

Missed Appointment Policy

We work diligently to see all our patients in a timely manner. Missed appointments leave us with holes in our schedule that prevents us from providing timely care for the children in our community. Missed appointments affect everyone. Therefore, we have instituted a "Missed Appointment Policy" which states that **appointments not cancelled within 48 hours minimum advance will be charged a fee of $50.00.** In the event that you miss 3scheduled appointments, we will release patient from the office and be happy to forward patient records to your dental office of preference.

Missed Oral Sedation and Operative Appointments

Due to the high demand for sedation appointments, we have implemented a "Missed Surgical / Operative Appointment Policy" to encourage patients to keep their appointments. If you cannot attend your scheduled appointment, you **must call** a minimum of 72 hours in advance. If we do not have a 72-hour advance notice of cancellation, you will be charged a **$200 non-refundable "Missed Surgical/Operative Appointment Fee"**.

Payment/Insurance Policy

As a courtesy, we file insurance claims for our patients. **All estimated out of pocket portions are due at time of service.** This amount is an estimate of your copayment and we work hard to make this as accurate as possible. **You are responsible for any amount not covered by your insurance.**

Our office accepts cash, check, Visa, MasterCard. We also offer financing through CareCredit and In-House financing.

I understand that I am responsible for the payment for all the fees for dental treatment that are not covered by the patient's dental or medical insurance. The parent or guardian who accompanies the patient to the appointment will be responsible for estimated portions due at the time of treatment, unless prior arrangements have been made. I agree that should the account be referred for collection, I will be responsible for all collections charges including attorney fees.

Parent/Legal Guardian Signature _____ Date _____

Springfield Kids' Dentist LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

_____

Please Print <<Print Your Full Name Here>>

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_ Individual refused to sign
_ Communications barriers prohibited obtaining the acknowledgement
_ An emergency situation prevented us from obtaining acknowledgement
_ Other (Please Specify)

_____

_____

Witness: _____

Consent to Treatment

Consent to Examine

It is our policy to keep you informed and involved in your child's dental progress. A typical examination consists of oral hygiene instruction, cleaning of the teeth, application of a topical fluoride, x-rays, and examination of the teeth, hard and soft tissue of the mouth, bite, and jaw. Except in an emergent situation or if existing disease is located, no further treatment will be performed during an examination. However, after the examination, we will create a treatment plan that may include fillings, caps, extractions, etc., and will seek your consent prior to performing the identified treatment. Treatment plans may cover multiple visits and once consent is obtained, we will not seek consent again unless the treatment plan changes. By signing below, you give consent for Springfield Kids' Dentist to perform an examination as outlined above. You further certify that you have legal authorization to consent to dental and medical treatment for the patient.

_____ _____ _____

Signature Relationship to patient Date

Alternative Consent

We recognize that it is not always feasible for the legal parent or guardian to accompany a child to his or her appointment or be available to provide consent for treatment. In an effort for us to ensure that the child is able to continue care, we would like to know if there are others who are authorized to consent to treatment for your child. By signing below, you give authorization for the person(s) listed to consent to recommended medical/dental treatment including, but not limited to, diagnosis, application of topical treatments (fluoride, sealants) x-rays, anesthesia, and invasive dental procedures. This authorization will remain in effect until you notify us in writing of any changes.

Name	Relationship to Patient	Phone Number

_____ _____ _____

Signature Relationship to patient Date