Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

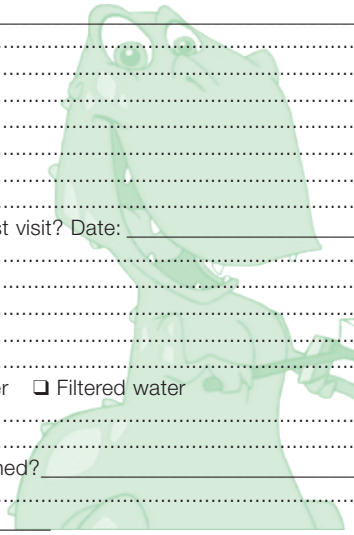
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Form S707

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Dat Complete Dentistry

43 S York Rd
Hatboro, PA 19040
www.datdentist.com

INSURANCE INFORMATION

Person responsible for account:
Last:_____ First: _____
Date of Birth: _____ SSN: _____
Address: _____
City: _____ State: _____ Zip: _____

Insurance Company: _____
Subscriber: _____ Date of Birth: _____
Subscriber Number: _____ Group Number: _____
Name of Employer/Company on Card: _____

SECONDARY INSURANCE

Insurance Company:_____
Subscriber: _____ Date of Birth: _____
Subscriber Number: _____ Group Number: _____
Name of Employer/Company on Card: _____

ASSIGNMENT AND RELEASE

I the undersigned, hereby authorize and direct my insurance carrier to pay directly to Dat Complete Dentistry all insurance benefits, if any, due to me under my insurance plan. I further agree to pay the balance of the charges not paid by my insurance. Any balance that is not paid within 45 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I agree a legal guardian gives consent for treatment for this and future service rendered.

Responsible Person/Patient Signature: _____
Date:_____

Dat Complete Dentistry Patient Financial Policy

Welcome to our office! We are honored that you have chosen us as your dental provider and look forward to working with you. Our practice is committed to providing an excellent dental care experience to you and your family and has implemented the financial policies outlined below to assist in that regard. These financial policies are followed by our practice so that we can stay focused on what we do best – providing you with personalized, comprehensive dental care services. Thank you in advance for your cooperation.

1. **Payment for all treatment is due at the time services are rendered unless other written payment arrangements have been made with our team in advance.**

2. **Payment for services may be made by cash, check, or credit card. We accept Visa, MasterCard, Discover and American Express. There will be a 3% surcharge for the credit card processing fee automatically added to your credit card.**

3. **We are pleased to offer financing through Care Credit. Those who qualify will use Care Credit as a form of payment at the time of service. Care Credit will have pre-approved of the patient and set up a monthly payment plan. This program is similar to a credit card and offers low monthly payments and flexibility to those who qualify, offered on an interest-free basis.**

4. **If you fail to show for a scheduled appointment or cancel and appointment with less that 24 hours advanced notice, the practice reserves the right to charge you a fee for such broken or late-changed appointment. The fee for broken appointments is $50 per appointment.**

5. **As a courtesy to our patients with dental benefits, we will submit your claims to your insurance company. Your insurance coverage is a contract between you, your employer and the insurance company – not your insurance company and us. It is your responsibility to familiarize yourself with your insurance coverage. Any portion not expected to be covered by these benefits is the responsibility of the patient and is due at the time dental treatment is performed. This amount will include deductibles and co-payments. Please understand that this is only an estimate – not a guarantee of payment and is based on the information available to us from your insurance company. Any insurance bill not settled within 60 days will be due in full and your responsibility to pay. Please be aware that some and perhaps all the services provided may be non-covered service.**

6. **If services are not paid for at the time services are delivered, you will be provided a statement for the amount due and will be expected to pay that amount in full promptly following receipt of the statement. Accounts unpaid after 60 days from the day or service are subject to a delinquent fee of $35. Furthermore, there is a $35 fee for any returned check. If the amount due is not paid in full within 60 days from the day services are delivered to you, the practice may refer the collection of the unpaid amount to a collection agency or collection attorney. If we must submit your unpaid account to a collections process, you will be responsible for all charges our practice incurs – including court costs and reasonable attorney's fees.**

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient Name: _____

Patient Signature: _____

Date: _____

PATIENT HIPAA CONSENT FORM

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 of 1996 (HIPAA). This provides a safeguard to my privacy.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. **Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient record, PHI and other documents or information.**
2. **It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.**
3. **The practice utilizes several vendors in the conduct of business. These vendors may have accessed the PHI but must agree to abide by the confidentiality rules of HIPAA.**
4. **You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.**
5. **You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.**
6. **Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.**
7. **We agree to provide patients with access to their records in accordance with state and federal laws.**
8. **We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.**
9. **You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.**

I _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Signature _____

Relationship to Patient _____

Date: _____

CONSENT TO PROCEED

I authorize Dr. Vu and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval. Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as PhenFen. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of nonhealing of the jaw bones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name:_____

Signature: _____ **Date:**_____
(Patient, legal guardian or authorized agent of patient)

Witness:_____ **Date:** _____