Pediatric Patient Information

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____ /_____ /_____ Social Security: _____-_____-_____ Gender: ◯ Male ◯ Female

Address: _____

City _____ State _____ Zip Code _____

Cell Phone Number: (_____) _____ - _____

Work Phone Number: (_____) _____ - _____

Home Phone Number (Land Lines Only): (_____) _____ - _____

Email: _____

Emergency Contact Information

Full Name: _____ Phone Number: _____

Relationship to Patient _____

How did you hear about us?

◯ Family / Friend / Co-worker

Who can we thank for your referral? _____

◯ Online (Google, etc.)

◯ Insurance

◯ Other

To the best of my knowledge, all the information I have provided is true

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient (or Parent/ Guardian) Relationship if not Patient

Pediatric Dental History Form

Patient's Name: _____ Date: _____

Is this your child's first visit to the dentist? ☐ Yes ☐ No

If no, when was the last visit and were radiographs (x-rays) taken? _____

Has your child seen an orthodontist or completed any orthodontic work? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any dental concerns that you want to address? _____

_____

Please check any of the following that may describe your child's attitude toward dentistry (Check all that apply)

☐ Cooperative	☐ Excited	☐ Friendly	☐ Shy
☐ Anxious	☐ Frightened	☐ Stubborn	☐ Uncooperative

Homecare:

☐ Yes ☐ No Does your child brush his/her teeth regularly?
If yes, how many times a day? _____

☐ Yes ☐ No Does your child use dental floss?
If yes, how often? _____

☐ Yes ☐ No Does an adult assist with brushing or flossing?

☐ Yes ☐ No Does your child use fluoride in any form? (Check all that apply)
☐ Toothpaste ☐ Drinking Water ☐ Mouth Rinse ☐ Other _____

Diet/Habits:

☐ Yes ☐ No Does your child snack frequently between meals?

☐ Yes ☐ No Does your child have sugar snacks? (e.g. raisins, fruit roll ups, candy)
If yes, how frequently? _____

☐ Yes ☐ No Does your child drink soda and/or juice?
If yes, how often? _____

☐ Yes ☐ No Does your child go to bed with a bottle or sippy cup?

☐ Yes ☐ No Have your child's teeth ever been injured?
If yes, which teeth? _____

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Nail Biting	☐ Teeth Grinding	☐ Mouth Breathing
☐ Toothache	☐ Thumb/Finger Sucking	☐ Cheek/Lip Biting	☐ Color of Teeth
☐ Sensitive Teeth	☐ Pacifier Sucking	☐ Jaw Sounds	☐ Other

Comments: _____

_____

_____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯Yes ◯No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯Yes ◯No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯Yes ◯No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯Yes ◯No If yes, please list: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯Yes ◯No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No _____
Are you on a special diet? ◯Yes ◯No _____
Do you use tobacco? ◯Yes ◯No _____
Do you use controlled substances? ◯Yes ◯No _____

Women: Are you:

Pregnant/Trying to get pregnant? ◯Yes ◯No Taking oral contraceptives? ◯Yes ◯No Nursing? ◯Yes ◯No

Are you allergic to any of the following?

◯ Aspirin ◯Penicillin ◯Codeine ◯Local Anesthetics ◯Acrylic ◯Metal ◯Latex ◯Sulfa Drugs
◯Other If other, please explain: _____

Do you have, or have you had, any of the following?

	Y	N		Y	N		Y	N		Y	N
AIDS/HIV Positve	◯	◯	Cortisone Medicine	◯	◯	Hemophilia	◯	◯	Radiation Treatment	◯	◯
Alzheimer's Disease	◯	◯	Diabetes	◯	◯	Hepatitis A	◯	◯	Recent Weight Loss	◯	◯
Anaphylaxis	◯	◯	Drug Addiction	◯	◯	Hepatitis B or C	◯	◯	Renal Dialysis	◯	◯
Anemia	◯	◯	Easily Winded	◯	◯	Herpes	◯	◯	Rheumatic Fever	◯	◯
Angina	◯	◯	Emphysema	◯	◯	High Blood Pressure	◯	◯	Rheumatism	◯	◯
Arthritis/Gout	◯	◯	Epilepsy or Seizures	◯	◯	High Cholesterol	◯	◯	Scarlet Fever	◯	◯
Artificial Heart Valve	◯	◯	Excessive Bleeding	◯	◯	Hives or Rash	◯	◯	Shingles	◯	◯
Artificial joint	◯	◯	Excessive Thirst	◯	◯	Hypoglycemia	◯	◯	Sickle Cell Disease	◯	◯
Asthma	◯	◯	Fainting Spells/Dizziness	◯	◯	Irregular Heartbeat	◯	◯	Sinus Trouble	◯	◯
Blood Disease	◯	◯	Frequent Cough	◯	◯	Kidney Problems	◯	◯	Spina Bifida	◯	◯
Blood Transfusion	◯	◯	Frequent Diarrhea	◯	◯	Leukemia	◯	◯	Stomach/Intestinal Disease	◯	◯
Breathing Problem	◯	◯	Frequent Headaches	◯	◯	Liver Disease	◯	◯	Stroke	◯	◯
Bruise Easily	◯	◯	Genital Herpes	◯	◯	Low Blood Pressure	◯	◯	Swelling of Limbs	◯	◯
Cancer	◯	◯	Glaucoma	◯	◯	Lung Disease	◯	◯	Thyroid Disease	◯	◯
Chemotherapy	◯	◯	Hay Fever	◯	◯	Mitral Valve prolapse	◯	◯	Tonsillitis	◯	◯
Chest pains	◯	◯	Heart attack/Failure	◯	◯	Osteoporosis	◯	◯	Tuberculosis	◯	◯
Cold Sores/Fever Blisters	◯	◯	Heart Murmur	◯	◯	Pain in Jaw Joints	◯	◯	Tumors or Growths	◯	◯
Congenital Heart Disorder	◯	◯	Heart Pacemaker	◯	◯	Parathyroid Disease	◯	◯	Ulcers	◯	◯
Convulsions	◯	◯	Heart Trouble/Disease	◯	◯	Psychiatric Care	◯	◯	Venereal Disease	◯	◯
									Yellow Jaundice	◯	◯

Have you ever had any serious illness not listed above? ◯Yes ◯No If yes, please list: _____

Comments: _____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

_____ _____
Print Patient Name Date

_____ _____
Signature of Patient (or Parent/ Guardian) Relationship if not Patient

HIPAA Consent Form

Consent for the use and disclosure of health information

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. Copies of our Notice of Privacy Practice are available at the front desk and on our website.

Persons Involved in Care: I give my consent for Complete Family Dentistry to discuss my dental treatment (past, present and future) and dental finances related to that treatment with the following person or persons:

_____ _____

Name (Printed) Relationship

_____ _____

Name (Printed) Relationship

Methods of Communication Consent: I authorize Complete Family Dentistry to contact me regarding my (or my child's) dental care via all methods I have provided (text, email, phone).

Wisconsin Consent: I consent to the diagnostic procedures and treatment by the dentist, hygienist, and/or assistant necessary for proper dental care. I consent to the dentist's use and disclosure of my (or my child's) records to carry out treatment, consult with other practitioners, obtain payment, and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing.

I authorize payment directly to the dentist or dental group of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and that I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. My consent will be effective until I revoke it in writing.

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient (or Parent/ Guardian) Relationship if not Patient

Financial Policy

Thank you for choosing Complete Family Dentistry for your dental needs. This agreement is to inform you of your financial obligation to our practice. We are committed to providing you and your family with comprehensive dental care using current techniques and high quality materials. We will always recommend treatment based upon your dental needs, not based on insurance coverage. All charges you incur for treatment that is provided are your responsibility regardless of your insurance coverage.

Full payment is due on the day of treatment
If we accept assignment of insurance, you are responsible for your estimated portion at the time of service. Any amount not covered by the insurance company will be billed to you. We request that patients without dental insurance be prepared to pay at the time of service.

Day of Service Payment Discounts
For those patients **without** dental insurance we offer discounts when payment is paid in full, at the time of service.
We offer: 7% Day of Service Courtesy Adjustment and 10% for those 60 and older. Only one discount can be applied to your bill.

Payment Options
Several payment options are available to assist you in fulfilling your financial obligations whether you have dental insurance or not. We accept: Cash, Check, Credit (Visa, MasterCard, Discover), Debit, HSA, FSA and Care Credit. A 3% Credit Card convenience fee will be applied to all credit card transactions to cover processing costs. There is no processing cost for debit card, HSA, or FSA transactions. Care Credit offers third party deferred interest financing options upon approval. For more information or to apply, visit www.carecredit.com

Insurance
Our office will file insurance claims on your behalf without a charge. It is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. Our office does not guarantee payment or coverage by your insurance company. Dental insurance usually pays only a portion of your charges and we urge you to be fully aware of the provisions of your dental plan's policy. You are responsible for your estimated portion at the time of service. Please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. Any remaining balance after your insurance has settled a claim and/or paid is your responsibility.

Broken Appointments
Since our time with our patients is very important to us and lost time is irretrievable, we reserve the right to charge for broken appointments when we have not been notified at least 24 hours in advance. Our charge for broken appointments is $50.00. Our desire is never to find it necessary to make this charge. Please keep your appointment, we are waiting for you.

Past Due Balances
Please note if your balance is not paid in full, interest rates may apply. Our policy is to charge 1.5% monthly interest that will be applied to all accounts 30 days past due. Any account 90 days past due may be turned over to collections. Fees incurred to collect payment will be billed to and payable by the responsible party on the account.

Returned Checks
We will charge $50.00 for returned checks.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am financially responsible for all dental services rendered to me and my dependents (if applicable).

_____ _____

Print Patient Name Date

_____ _____

Signature of Patient (or Parent/ Guardian) Relationship if not Patient