Dentists 4 Children

PATIENT INFORMATION

TODAYS DATE: _____

NAME (FIRST, MIDDLE, LAST): _____ DOB: _____

PREFERRED NAME: _____ SEX: ☐FEMALE ☐MALE

ADDRESS, CITY, STATE, ZIP: _____

APPT REMINDER TEXT#: _____ APPT REMINDER EMAIL: _____

PARENT OR GUARDIAN INFORMATION

MOTHER'S NAME (FIRST, MIDDLE, LAST) _____ DOB: _____

ADDRESS, CITY, STATE, ZIP: _____ SS#: _____

HOME#: _____ CELL#: _____

EMAIL: _____ EMPLOYER/WORK#: _____

EMERGENCY NAME AND PHONE#: _____

FATHER'S NAME (FIRST, MIDDLE, LAST): _____ DOB: _____

ADDRESS, CITY, STATE, ZIP: _____ SS#: _____

HOME#: _____ CELL#: _____

EMAIL: _____ EMPLOYER/WORK#: _____

EMERGENCY NAME AND PHONE#: _____

PREVIOUS DENTIST, CITY, STATE, ZIP, PHONE#: _____ ALLOW RECORDS RELEASE: **YES**

HIPAA NOTICE OFFERED ON WEBSITE: **YES** ALLOW VOICE, EMAIL, TEXT REMINDER MESSAGE: **YES** ALLOW PATIENT PORTAL: **YES**

PRIMARY DENTAL INSURANCE INFORMATION: ☐ N/A

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

SUBSCRIBER EMPLOYER: _____ DENTAL INSURANCE COMPANY: _____

DENTAL CLAIMS ADDRESS: _____ DENTAL CLAIMS PHONE#: _____

PLAN NAME/ GROUP#: _____ CONTRACT/POLICY# OR SS#: _____

SECONDARY DENTAL INSURANCE INFORMATION: ☐ N/A

SUBSCRIBER NAME: _____ SUBSCRIBER DOB: _____

SUBSCRIBER EMPLOYER: _____ DENTAL INSURANCE COMPANY: _____

DENTAL CLAIMS ADDRESS: _____ DENTAL CLAIMS PHONE#: _____

PLAN NAME/ GROUP#: _____ CONTRACT/POLICY# OR SS#: _____

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Date: _____

Patient Name: _____ **Patient Date of Birth:** _____

Name of Person Updating: _____ **Relationship:** _____

Due to HIPAA Laws, Is Patient Over 16 Years of Age? ☐Yes ☐No

Is the Patient Pregnant? ☐YES ☐NO ☐OVER 16 YRS OF AGE ☐MALE

Allergic to Food or Medications? ☐YES ☐NO ☐NONE KNOWN

If Yes, Please List: _____

Any Dairy Allergies? (for MI Paste) ☐YES ☐NO

If Yes, Which Allergies? ☐Casein (milk protein) allergy ☐Paraben allergy ☐Whey allergy
☐Undergoing dialysis ☐Salicylates allergy ☐Titanium dioxide allergy
☐Xylitol allergy ☐Diagnosis of Phenylketonuria (PKU) ☐None

Any Fluoride Varnish Allergy? (Peanut or Tree Sap) ☐YES ☐NO

If yes, Which One? ☐Peanuts or Nuts in general ☐Pine Tree Sap ☐None

MEDICAL HISTORY: ☐ADD/ADHD ☐Anemia ☐Asthma ☐Autism/Mental Challenges or Delays
☐Cancer or Tumor ☐Cerebral Palsy ☐Chronis Sinus
☐Cystic Fibrosis ☐Depression/Anxiety ☐Excessive Bleeding ☐Hemophilia
☐Von Willebrand Disease ☐Idiopathic Thrombosis ☐Fainting Spells
☐HIV/AIDS ☐Kidney or Bladder ☐Language Delays ☐Liver or Hepatitis
☐Mastoid ☐Physical Challenges ☐Sickle Cell or Trait ☐Thyroid
☐Tuberculosis ☐(MTHFR) methylenetetrahydrofolate reductase
☐NONE ☐Notes: _____

If Yes, List Diagnosis Date, Physician, Phone#: _____

Currently Taking Medications for ADD/ADHD? ☐Yes ☐No **NAME/DOSE:** _____

Any Other Medications? ☐YES ☐NO **If Yes, Medications & Dosage Info:** _____

Ever Had HEART ISSUES (Even at Birth)? Ex: Murmur, Valves, Surgeries, etc? ☐YES ☐NO

If Yes, Cardiologist Name? _____ **Phone #?** _____

SBE Needed for Heart Coverage? ☐YES ☐NO ☐N/A

Ever Had Chicken Pox, Measles, Mononucleosis, Mumps, Rheumatic Fever? ☐YES ☐NO

If Yes, When? _____

Patient's Pediatrician, City, State, Zip and Phone#: _____

Excessive Bleeding When Cut? ☐Yes ☐No ☐Unsure

If Yes, Please Explain: _____

Ever Been Hospitalized? ☐Yes ☐No

If Yes, List When and Why: _____

Any Surgeries? ☐Yes ☐No

If YES, list why and when: _____

Complained of Dental Problems? ☐Yes ☐No

If Yes, Please Explain: _____

Is Fluoride Given in Home? (water, toothpaste, etc) ☐Yes ☐No ☐Unsure

Source? _____

Please list any other medical treatment, injuries, physical or emotional needs that we need to be aware of:

I, the undersigned parent, or guardian of the above patient, am hereby disclosing my child's health history information, including current medications, allergies, reactions to medicine, diseases/chronic illness, and past procedures. I have updated all registration history including address, phone number, financial and insurance information and/or changes with Dentists 4 Children, LLC.

I understand that my insurance claims will be filed as a courtesy and that all co-pays and deductibles will be paid at time services are rendered. I understand that my payment at time of service is only an estimate until all claims have been received from my insurance company. At which time a statement will be sent for any remaining balance. I understand that I will be financially responsible for any treatment I choose that is not covered by my insurance plan. I understand that I am agreeing to this patient's treatment, therefore, I am the responsible party regardless of who carries the dental insurance as well as custody/divorce decrees. I agree to all financial responsibility including any collection fees associated with past due accounts.

I understand that I have a right to Dentists 4 Children, LLC HIPAA policies and all questions and concerns have been asked and answered concerning all new OSHA and COVID19 safety protocols.

I have reviewed and verified this information to be true. I agree to notify Dentists 4 Children, LLC with all changes that may occur in the future. I understand that with holding this information may affect the outcome of the procedure(s) or course(s) of treatment and/or future treatment.

I am a native speaker of English or have brought a qualified translator who has explained the information in my native tongue.

_____ _____

Print Parent or Guardian's Name **Relationship to Patient**

X _____ _____

Parent of Guardian's Signature **Date**