PATIENT'S CONFIDENTIAL INFORMATION

PATIENT INFORMATION

Child's Full Name: ______________________________ Nickname: ____________________
Date of Birth: ____________________ Age: ________ SS#:____________________ Sex: M F
Address: ____________________ City: ______________ State: ______ Zip: ________
How did you hear about our office? ______________________________

PARENT/GUARDIAN INFORMATION

Father/Guardian Name: ____________________ Date of Birth:______________ SS#______________
Address: Same as patient? Yes No
If not, please list: ____________________ City: ______________ State: ______ Zip: ________
Contact Information: Preferred Phone#____________________ Text: Yes No
Alternate Phone #____________________ Email: ____________________
Marital Status: Single Married Divorced Widowed Separated

Mother/Guardian Name: ____________________ Date of Birth:______________ SS#______________
Address: Same as patient? Yes No
If not, please list: ____________________ City: ______________ State: ______ Zip: ________
Contact Information: Preferred Phone#____________________ Text: Yes No
Alternate Phone #____________________ Email: ____________________
Marital Status: Single Married Divorced Widowed Separated

Who has legal custody of this patient? ______________________________

INSURANCE INFORMATION

Please fill out the following information if you have insurance benefits that you would like applied to your account.

PRIMARY INSURANCE:	**SECONDARY INSURANCE:**
Policy Holder:____________________	Policy Holder:____________________
Soc. Sec. #: ____________________	Soc. Sec. #: ____________________
Occupation: ____________________	Occupation: ____________________
Employer:____________________	Employer:____________________
Insurance Carrier: ____________________	Insurance Carrier: ____________________
Member ID#: __________Group #: __________	Member ID#: __________Group #: __________
Relationship to Patient: ____________________	Relationship to Patient: ____________________

MEDICAL HISTORY

Child's Physician: ____________________ Preferred Pharmacy:____________________

Do you consider your child to be in good health? Yes No
(Explain):______________________________
Has your child ever had a health problem? Yes No (List):
____
Has your child ever been hospitalized or had any surgical procedures? (Reasons & Dates): ____________________
____
ALLERGIES: Is your child **allergic** to any medications/latex/foods? Yes No (List):

____

Is your child taking any **medications**? Yes No (List):

____

Were there any problems at birth?

____

Please check if your child has a history of any of the following:

Asthma/Reactive Airway	Autism/PPD	ADA/ADHD
Cancer/Tumors	Cleft Lip/Palate	Epilepsy, seizures, fainting
Ear Infections/Tubes	Diabetes	Developmental Delay
Heart disease or murmur	HIV/AIDS	Speech Delay
Liver Disease/Hepatitis	Kidney Disease	Genetic Disorder/Syndrome
Hearing or Vision Problems	Chemical Dependency	Motor or muscle disorder
Blood disorder/transfusions	Sleep Apnea/Snoring	Premature birth (weeks? ______)

Females Only: Is there any possibility of pregnancy? Yes No Taking birth control? Yes No

Is your child adopted? Yes No Does he/she know? Yes No

Does your child have any other medical issues or special needs? Yes No (Please List):

____

____

DENTAL HISTORY

On a scale from 1-10, with 10 being the highest:

- How important is your child's dental health to you? 1 2 3 4 5 6 7 8 9 10
- Where would you rate your child's current dental health? 1 2 3 4 5 6 7 8 9 10

What sources of fluoride does your child receive?	How often does your child consume the following liquids (Please circle):
Toothpaste	
Home water supply	**Milk:** Never 1x/month 1x/week Daily
Over-the-counter rinse	**Juice:** Never 1x/month 1x/week Daily
Prescription rinse	**Soda:** Never 1x/month 1x/week Daily
Prescription drops/tablets/vitamins	**Coffee/Tea:** Never 1x/month 1x/week Daily
Fluoride treatment by pediatrician/ other practitioner	**Sport Drinks:** Never 1x/month 1x/week Daily

Does your child have a history of sucking on a **finger** or **pacifier**? Yes No

If yes, have they stopped? Yes (At what age? _____) No

Is your child currently being **breast fed**? Yes No … **formula fed**? Yes No

If no, at what age was it discontinued? ____

Does your child currently use a **sippy cup**? Yes No

If yes, what is placed in the cup: ____

Who performs brushing and flossing: Child Parent/Guardian

Frequency: Brushing ______ # per day / week Flossing _____ # per day/ week

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

Cavities	Bad breath	Orthodontics/Crowding Issues	Bleeding gums
Toothache/Pain	Jaw Joint Problems	Sensitive Teeth (hot, cold, sweet)	Teeth or fillings breaking

Please share the following information and dates if applicable:

Name of Previous Dentist: _________________________________ Your child's last cleaning __________/_________ or N/A

City: __________________________________ State: __________ Your child's last oral cancer screening _________/_________

Phone #: ____ Your child's last complete x-rays ___________/__________

Why did you leave your previous dentist? ____

What is the most important thing to you about your child's future smile and dental health? ______________________

____

Has your child had any unfavorable experience with previous dental care? Yes No(Please explain):

CONSENT FOR DENTAL CARE AUTHORIZATION FOR NON-PARENT/GUARDIAN

I give my permission for the following adults to accompany my child to future dental appointments and make treatment decisions concerning my child when I am not present:

Name: ____Relationship: _________________________________

(This consent shall be effective from date of signature until revoked by parent or legal guardian.)

PARENT/GUARDIAN Signature: ____ Date: ________________

WEBSITE AND SOCIAL MEDIA RELEASE FORM

(Patient Name) ______________________________ has my permission to have his/her dental work and/or photographs posted within our dental practice and/or on our website, social media accounts, videos or slide show presentations, print ads and all other marketing or advertising efforts that promote our dental practice.

PARENT/GUARDIAN Signature: ____ Date: ________________

PATIENT SIGNATURE if 18 years or older: ____ Date: ________________

OFFICE POLICIES & MATERIALS FACT SHEET

The following agreements and policies are in place to ensure that we can provide the best, most positive dental experience for your child. Please feel free to ask anyone in the office if you have a question or questions. Thank you for allowing us the opportunity to provide dental care for your child.

I have received and reviewed copies of Barstow Children's Dentistry's:

- Notice of Privacy Practices*
- Parental Agreement & Guidelines
- Dental Materials Fact Sheet

***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. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Patient name: ____

I (PLEASE PRINT),_____________________________________, agree to follow the above policies and agreement.

PARENT/GUARDIAN Signature: ____ Date: ________________

CONSENT FOR DENTAL TREATMENT AND FINANCIAL POLICY

I request and authorize the Doctor/Doctors and staff at Barstow Children's Dentistry to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the Doctor/Doctors to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic and educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The Doctor/Doctors and their staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tones. As a condition of treatment by this office, I understand that I will be responsible for the payment of all fees at the time of service unless other arrangements have been made. Payment may be by check, Visa, MasterCard, Discover, or American Express. For patients with insurance, I understand that the estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is my responsibility to pay within 60 days. I hereby authorize payment of dental insurance benefits, if any to be made directly to the Doctor/Doctors of Barstow Children's Dentistry. We understand that emergencies happen, but for cancelled cleaning appointments with less than 24 hours notice, there will be a $25.00 charge. For any Nitrous Oxide, Oral Sedation, General Anesthesia or Operative appointment cancellation with less than 24 hours notice, there will be a $50.00 charge. (Certain circumstances do not apply to cancellation fees). For Oral Sedation or General Anesthesia appointments, there will be a $100.00 deposit for the appointment. It will be collected at time of scheduling the appointment and will be used towards the charges on the day of treatment. In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services, and I agree to pay all collection fees, court costs and reasonable attorney fees incurred by my failure to remit for services rendered. Returned checks will have a $15.00 charge added and balance over 90 days may be subject to interest charges of 1.5% per month. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree to its content.

PARENT/GUARDIAN Signature ____ Date ___________________