WELCOME

1 About Your Child

Today's Date: ____/____/____ File #:__________

Child's Name: __________ LAST FIRST M.I.

Child's Nickname: __________ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: ______

School: __________ Grade:______

Child's Home Phone #: (_____) __________

Child's SS#: __________

Child's Address: __________ HOME ADDRESS

__________ CITY STATE ZIP

Referred By: __________ (If doctor, please give address & phone number)

____

2 Insurance Information

Primary Dental Insurance

Co. Name: __________

Address: __________

__________ CITY STATE ZIP

Phone #: __________

Insured's SS#: __________

Group # (Plan, Local, or Policy #): __________

Insured's Name: __________

Relation: __________ Date of Birth: ___/___/___

Insured's Employer: __________

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: __________

Address: __________

__________ CITY STATE ZIP

Phone #: __________

Insured's SS#: __________

Group # (Plan, Local, or Policy #): __________

Insured's Name: __________

Relation: __________ Date of Birth: ___/___/___

Insured's Employer: __________

3 Child's Family Information

Who is accompanying this child today?

__________ FULL NAME IF OTHER THAN PARENT __________ RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? ______ Age(s): __________

Mother's Name: __________ ❑ STEPMOTHER ❑ GUARDIAN

❑ **CHECK IF SAME AS CHILD'S** HOME ADDRESS CITY STATE ZIP

(______) __________ HOME PHONE # (______) __________ WORK PHONE # EXT.

__________ MOTHER'S SOCIAL SECURITY # ___/___/___ DATE OF BIRTH __________ MOTHER'S DRIVERS LIC. #

Employer:__________ How Long?______

__________ EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: __________ ❑ STEPFATHER ❑ GUARDIAN

❑ **CHECK IF SAME AS CHILD'S** HOME ADDRESS CITY STATE ZIP

(______) __________ HOME PHONE # (______) __________ WORK PHONE # EXT.

__________ FATHER'S SOCIAL SECURITY # ___/___/___ DATE OF BIRTH __________ FATHER'S DRIVERS LIC. #

Employer:__________ How Long?______

__________ EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account:

Name: __________ __________ RELATION TO CHILD

Billing Address: __________

__________ CITY STATE ZIP

__________ SOCIAL SECURITY # ____/____/____ DATE OF BIRTH __________ DRIVER'S LIC.#

(______) __________ WORK PHONE # EXT. (______) __________ CELL PHONE#

Payment method: ❑ Cash ❑ Check

__________ ____/____ EXPIRES

❑ Credit Card - Enter card # above (if accepted)

X ______ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I truly understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ☑ No ❑ Yes How Long? ____________________

Please indicate ❑ any of the following problems:

❑ Discomfort, clicking or popping in jaw	❑ Lost/Broken Filling(s)	❑ Stained teeth
❑ Red, swollen or bleeding gums	❑ Teeth grinding	❑ Locking Jaw
❑ Sensitive tooth, teeth or gums	❑ Ringing in Ears	❑ Bad breath
❑ Blisters/Sores in or around the mouth	❑ Broken/Chipped tooth	❑ Loose tooth

❑ Other(s): ____________________

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ____________________ (_____) ____________

Last Dental exam: _____/_____/_____ Last Dental X-rays: _____/_____/_____

Times a day child brushes?__________ Time a week child flosses? __________

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? Best 1 2 3 4 5 6 7 8 9 10 Worst

6 Child's Medical History

Is Child taking any of the following mediations: ❑ Pain Killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle Relaxers ❑ Others: __________

Child's Physician: ______________________________ (_____) ____________
DOCTOR'S NAME OR CLINIC NAME PHONE #

______________________________ Last Medical Exam:_____/_____/_____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	Y N Hearing Problems	Y N Cleft Lip/Palate
Y N Rheumatic Fever	Y N Tonsillitis	Y N Birth Defects
Y N Artificial Heart Valves	Y N Respiratory Problems	Y N High/Low Blood Pressure
Y N Congenital Heart Defect	Y N Asthma/Difficulty Breathing	Y N Hepatitis
Y N Scarlet Fever	Y N Blood Transfusion(s)	Y N Artificial Bones/Joints/Implants
Y N Surgeries/Operations	Y N Leukemia/Anemia	Y N Liver/Kidney/Organ Problems
Y N Cancer/Tumors	Y N Diabetes/Hypoglycemia	Y N HIV+/AIDS/ARC
Y N Chemotherapy	Y N Hemophilia	Y N Tuberculosis TB
Y N Jaw Problems TMJ/TMD	Y N Abnormal Bleeding	Y N Psychiatric Problems
Y N Hyper Active/ADD	Y N Fainting/Seizures/Epilepsy	Y N Cerebral Palsy

Please list any other medical condition(s) child has or ever had: ____________________

____

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine) ❑ Aspirin ❑ Food Allergies ❑ Other(s): ____________________

Please rate the child's general health from 1-10:_______ Does child wear contact lenses? ❑ Yes ❑ No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long?_______ Child's Blood Type:_______

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking ❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: X ______________________________ Date _____/_____/_____
❑ Parent or Guardian ❑ Other:

UPDATE
(OFFICE USE)

Initials ____ Date __/__/__
Comments

Initials ____ Date __/__/__
Comments

Initials ____ Date __/__/__
Comments

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby acknowledge receipt of a written notice of my privacy rights and I consent to CITY CREEK DENTAL using and disclosing my protected health information to carry out treatment, payment or health care operations.

I understand and have been provided with a Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I understand that I have the right to review the notice prior to signing the consent.

I understand that CITY CREEK DENTAL reserves the right to change their notice and information practices and that I may obtain a copy of the revised notice by written request addressed to CITY CREEK DENTAL, 803 S 37th St, Temple, TX 76504.

I understand that I have the right to restrict how CITY CREEK DENTAL uses or discloses my protected health information to carry out treatment, payment or health care operations and that CITY CREEK DENTAL is not required to agree to the restrictions and that CITY CREEK DENTAL is bound by restrictions to which it agrees.

I request that the following restrictions to how my health information is used or disclosed:

____

____

____

____

____

____

____

I have the right to revoke this consent by notifying CITY CREEK DENTAL in writing, except to the extent that CITY CREEK DENTAL has taken action in reliance on my consent.

X ______________________________ ____________________

Signature of patient or representative Date

____

Printed name of patient or representative