Child Health/Dental History Form

ADA
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:

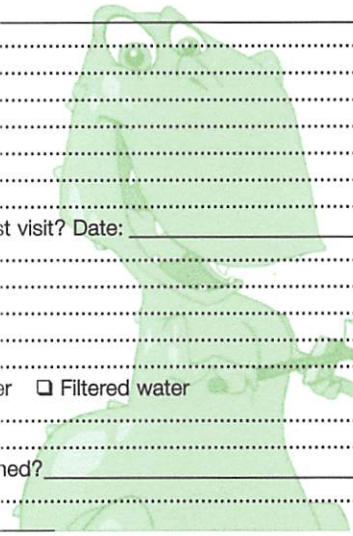
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic 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

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Deefield Family Dentistry
Tracey Pike, DMD
Patient Registration Form

Patient Name: _____
Preferred Name:_____ Birth Date:_____
SS#:_____Drivers Lic #:_____ Marital Status: S__M__D__W__
Home Address:_____
City:_____ State:_____ Zip:_____
Home #:_____ Cell #:_____
Employer Name and Address_____
Occupation:_____ Work #:_____
E-mail Address:_____
Would You Like to Receive Dental Reminders Via Text/E-mail? Y_____ N_____
Referred By_____

Person Responsible for Account (If Other than Patient):_____
Relationship:_____ SS#:_____ Birth Date:_____
Home Address (If Different):_____
Employer Name and Address:_____
Occupation:_____ Work #:_____

Emergency Contact Information (relative not living with you)

Name:_____
Address:_____
City:_____ State:____ Zip:_____ Phone #:_____

Primary Dental Insurance Information	**Secondary Dental Insurance Information**
Insured's Name:_____	Insured's Name:_____
Insured's DOB:_____	Insured's DOB:_____
Insured's Employer:_____	Insured's Employer:_____
Insured's Company:_____	Insured's Company:_____
Group #:_____	Group #:_____
Ins. Company Phone #:_____	Ins. Company Phone #:_____

Name on Credit Card:_____
Credit Card #:_____ Authorization Code:_____
Expiration Date:_____ Credit Type (MC/Visa/Discover/Amex):_____
To be used for Services not covered by Insurance

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE & CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

I may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

_____ _____
Printed Name Signature

Dependents:
_____

How would you like to be addressed when summoned from the reception area:
{ } First name only { } Proper sir name { } Other:_____

Please list any other parties who can have access to your health information:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

I authorized Deerfield Family Dentistry to confirm my appointments, treatment and billing information via:
{ } cell phone { } text message { } home phone
{ } work phone confirmation { } email confirmation { } any of the above

I authorize information about my health be conveyed via:
{ } cell phone { } text message { } home phone
{ } work phone confirmation { } email confirmation { } any of the above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote you improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule provide you this information with your knowledge and consent.

Office use only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
{ } Emergency treatment { } I could not communicate with the patient

{ } The patient was unable to sign because:_____

{ } Other:_____

DEERFIELD FAMILY DENTISTRY PLLC

Deerfield Family Dentistry
Financial Policy

Thank you for choosing our office as your dental health care provider. Our office provides quality, comprehensive dentistry to our patients. In return, our patients are responsible to us for their financial obligation. Insurance benefits are a terrific aid in helping to fulfill those obligations. We are a Delta Premier Provider. Our office will assist you at no charge in securing the maximum insurance benefits you are entitled to. **IT IS NOT OUR RESPONSIBILITY NOR OUR INTENT TO ACT AS MEDIATOR BETWEEN YOU AND YOUR INSURANCE COMPANY.** Your insurance policy is a contract between you, your employer, and your insurance company. **IT IS YOUR RESPONSIBILITY TO MONITOR YOUR REMAINING BENEFITS AVAILABLE** so as to not unexpectedly run over the maximum.

We ask that you pay your portion on the day of services. We accept cash, checks, MasterCard, Visa, American Express, and Discover cards. There is a fee of $25 for any returned checks. **WE DO NOT ACCEPT MONTLY PAYMENT PLANS.** Most insurance companies will reimburse patients within two weeks. If your insurance carrier has not paid their portion within 60 days of the date of service, that balance now becomes your responsibility also.

Any balance unpaid after 30 days is subject to an interest rate of 10%. Be aware that your failure to keep your account current may result in Deerfield Family Dentistry being unable to provide additional dental services except for dental emergencies. In case of default on payment of this account, you will be charged the collections costs and reasonable fees incurred in attempting to collect on this amount or any future outstanding account.

Due to staffing requirements, for your visit there will be a charge of $75.00 for any missed appointments. If unable to keep an appointment, 72 hours notice is required to avoid this fee.

We offer 5% senior citizen discount to our patients 65 years young.

We offer discounts for payments made before your scheduled appointment.

We also offer Care Credit, which is an extended financing solution to include up to 12 months of interest free loans.

By signing, you are also authorizing release of any medical or other information necessary to process a claim. You are also authorizing payment of benefits for services rendered to either Dr. Pike or the subscriber according to the policy of her practice.

The undersigned herby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment of Dental Services provided in this office for myself or my dependents is mine. I further understand that a finance charge or any fees associated with collection of an overdue account will be added to any overdue balance. I hereby authorize this office to obtain a credit report from a credit reporting agency for the purpose of considering payment options.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient/Guardian Signature _____ Date _____

I have been offered copies of Dr. Pike's "Notice of Privacy Practices" and the Dental Restorative Materials Fact Sheet and have been given the opportunity to ask any questions that I may have regarding these "Notices".

Patient/Guardian Signature _____ Date _____
*some restrictions may apply