Child Patient Information

Child Information

Today's Date _____ Patient Name (last, first, middle initial) _____

Preferred Name_____ Gender _____ Birthdate _____

SSN_____ School _____ Grade _____

Prefer contact by: ☐ email ☐ phone call ☐ text

How did you hear about us? _____

Home Phone (____) _____ Street Address _____

City _____ State _____ Zip _____

Parent/Guardian's Cell # (____) _____ Parent/Guardian's Work # (____) _____

Parent/Guardian's Email Address _____

Additional Information

Mother's Name _____ Father's Name _____

Mother's Employer _____ Father's Employer _____

Mother's Birthdate _____ Father's Birthdate _____

Mother's SSN _____ Father's SSN _____

Mother's Phone # _____ Father's Phone # _____

Person financially responsible (if other than parent) _____ Relationship to child _____

What is child's favorite: Sport? _____ Toy? _____

Hobby? _____ Fictional character? _____

Dental Insurance Information

Does the child have dental insurance? ☐ Yes ☐ No

Subscriber's Name_____ Insurance Co._____

Relationship to Patient_____ ID #_____

Subscriber's Birthdate_____ Policy #_____

Subscriber's SSN_____ Group #_____

Is this through an employer? ☐ Yes ☐ No

Employer:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company[ies]) and assign directly to Smiles for Life all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

The above-mentioned dentist may use my health care information and may disclose such information to the above-mentioned Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Smiles for Life DENTAL CARE

Child Dental History

Date of last visit to a dentist _____ For what service? _____

YES	NO	
☐	☐	Does the child have dental pain?
☐	☐	Has the child had any unhappy dental experiences?
☐	☐	Has the child had any injuries to mouth, teeth or head?
☐	☐	Does the child have any mouth habits? (thumb-sucking, nail-biting, mouth breathing, nursing bottle habits, pacifier, etc.)
☐	☐	Does the child have any unusual speech habits?
☐	☐	Does the child have any prematurely lost teeth?
☐	☐	Has the child been treated for orthodontics? Has the child worn orthodontic appliances?
☐	☐	Does the child brush teeth daily?
☐	☐	Do you assist the child with tooth brushing? If yes, how often?
☐	☐	Is dental floss used? If yes, how often?
☐	☐	Are disclosing tablets used?
☐	☐	Is fluoride taken in any form?
☐	☐	Do you desire comprehensive dental service for the child?

Any additional notes about the child's attitude toward dentistry or past treatment?

_____

_____

_____

Smiles for Life DENTAL CARE

Child Health History

Child's name: _____ Child's Date of Birth: _____

Name of Legal Guardian: _____ Phone: _____

Child's Physician: _____ Date of last physical: _____

YES	NO	
☐	☐	Is the child presently being treated for any illness or condition?
		_____
☐	☐	Is the child receiving any medication or drugs?
		_____
☐	☐	Has the child ever been hospitalized? Had surgery?
		_____
☐	☐	Does the patient have an allergy to penicillin or other drugs?
		_____
☐	☐	Does the patient have any other allergies? (food, pollen, animals, dust, other)
		_____
☐	☐	Does the child have good physical coordination?
		_____
☐	☐	Does the child have any emotional problems?
		_____

Has the child had any history of or difficulty with any of the following:

__ ADHD	__ Chronic sinus infection	__ Kidney problems	__ Tuberculosis
__ Anemia	__ Convulsions	__ Liver problems	__ Venereal disease
__ Asthma	__ Diabetes	__ Malignancies	__ Other
__ Autism	__ Down's Syndrome	__ Measles	If other, please describe:
__ Bladder problems	__ Epilepsy	__ Mononucleosis	_____
__ Bed wetting	__ Fainting	__ Mumps	_____
__ Bleeding problems	__ Frequent ear infections	__ Rheumatic fever	_____
__ Cerebral Palsy	__ Hearing problems	__ Seizure	_____
__ Chicken Pox	__ Heart problems	__ Thyroid problems	_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information of which we should be aware. _____

_____

Parent/ Legal Guardian Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Consent to Treat Minor without Parent/Legal Guardian Present

Patient's Full Name: _____ Date of Birth: _____

To allow for treatment of patients who are considered minors, it is necessary for a parent or legal guardian to give consent for treatment. In the event that a minor child presents for a non-urgent appointment without a parent or legal guardian or a signed consent, treatment may be denied.

- I, the parent or legal guardian of _____, consent to:
  (child's name)

  _____ Emergency or urgent care when I cannot be reached.

  _____ Routine dental care, which may include, but is not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, x-rays and any and all other treatment previously discussed and agreed upon by the parents/legal guardian.

- I grant permission to _____ _____ to bring my
  (name) (relationship to child)
  child to their appointments and to make treatment decisions for the child in my absence.

- I can be reached at the following number if there are any questions: _____

I _____ authorize Smiles for Life Dental Care to provide treatment.
(Printed name of Parent/Guardian)

_____ _____

Signature of Parent/Guardian Date

HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information (PHI) may be disclosed or used for treatment, payment, or healthcare operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition treatment upon execution of this Consent.

Below is a list of ways the office may contact you. Checking the first box will give permission to leave as thorough of a message as needed from your dental office. This will include, but is not limited to, appointments day, time, and treatment scheduled; documents to be signed; financial and collection concerns; or pre– and post-treatment directions. Any source other than the USPS, example: cell phones, email, and fax lines, are not considered 100% secure. Contact information will be verified by patient.

_____ Patient gives office permission to use any contact written on patient registration form.

Please check any that you DO NOT want the office to call. We will be using the numbers/emails you have updated on your Account information. All information is subject to availability to verify and validate.

___ Work Cell	___ Work Phone	___ Work Email	___ Home Fax	___ **Any of the above**
___ Personal Cell	___ Home Phone	___ Home Email	___ Mail to Work	
___ Emergency Contact	___ Interpreter Contact	___ Work Fax	___ Mail to Home	

List names of who can have access to your dental chart information. Circle type. If Partial, state what part of your chart (Financial, Treatment, and/or Health History) is allowed to be disclosed or copied.

_____ **Full** access / **Partial** access _____

_____ **Full** access / **Partial** access _____

_____ **Full** access / **Partial** access _____

_____ Patient gives office permission to forward any verified contact information and PHI to patients specialists. Office may discuss pertinent patient chart information, including PHI, with labs, and product representatives involved in patient's case through verified, unsecured, unsecured, unencrypted means. The Privacy Rule allows those doctors, nurses, hospitals, laboratory technicians, and other healthcare providers that are covered entities to use or disclose protected health information, such as x-rays, laboratory, and pathology reports, diagnoses, and other medical information for treatment purposes without the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient. See 45 CFR 164.506. Any source other than your Healthcare Providers will sign a Business Associate Agreement. Patient understands if permission is not granted, USPS is the only means of communication with those involved in patients case, which is considered HIPAA compliant. Treatment may take considerably longer in this case. This office will not be held responsible for any delay in mail which then causes an increase in treatment time or treatment costs. Patients or approved contacts may request and pick up copies of PHI to be hand delivered.

Print Patient's Name: _____ **Date:** _____

Print Legal Guardian's Name: _____ **Date:** _____

Signature of Patient or Legal Guardian: _____ **Date:** _____

____ Patient refused to sign HIPAA Consent. Patient has the right to refuse. USPS or patient pick up will be used for PHI transfer.

Office Staff Signature: _____ **Printed Name:** _____ **Date:** _____

Witnessed Staff Signature: _____ **Printed Name:** _____ **Date:** _____