WELCOME TO COLLEYVILLE CHILDREN'S DENTISTRY

TELL US ABOUT YOUR CHILD

Name:

SS#: ____-___-_____ Gender: M / F

Birth Date: ____/_ ___/____ Age: ____

Home Address:

Phone:

How'd you hear about us?

PRIMARY DENTAL INSURANCE

Employer:

Policy Holder:

Policy Holder's DOB: _____/_____/_ __

SS #: ____-___-_____

Relationship to patient:

Insurance Co. Name:

I.D. #_____________ Group #: ___________

Insurance Co. Phone #:

Insurance Co. Address:

FATHER'S INFORMATION

Name:

DOB: ____/____/____ SS #: ____-___-_____

Home Address:

Home/Cell #:

Email:

MOTHER'S INFORMATION

Name:

DOB: ____/____/____ SS #: ____-___-_____

Home Address:

Home/Cell #:

Email:

DENTAL HISTORY (CONFIDENTIAL)

Does your child have a history of, or is your child currently doing any of the following?		
Pacifier	Yes	No
Suck Thumb / Finger	Yes	No
Suck / Bite Lip	Yes	No
Bite / Chew Nails	Yes	No
Grind Teeth	Yes	No
Was your child		
Bottle Fed	Yes	No
Breast Fed	Yes	No

MEDICAL HISTORY (CONFIDENTIAL)

Physician's Name: Phone # :		
Date of Last Visit :		
Previous Hospitalizations / Surgeries / Serious Illness : When?		
Had a Blood Transfusion	Yes	No
Are immunizations up to date	Yes	No
Is your child taking any medication:	Yes	No
Is your child Allergic to any medications?	Yes	No
Has your child ever developed any condition including bleeding, drug or anesthesia reaction or rash requiring special treatment after last dental visit?	Yes Explain :	No

HEALTH HISTORY (CONFIDENTIAL)

Does your child have a Blood Disorder? Yes No

Anemia	Yes		Von willebrand	Yes
Hemophilia	Yes		Sickle Cell	Yes
Excessive Bleeding	Yes			

If you answered yes to any of these, please explain: ______________________________________

Does your child have a Heart Condition?	Yes	No		
Artificial Valve	Yes		High Blood Pressure	Yes
Congenital Heart Defect	Yes		Low Blood Pressure	Yes
Heart Disease	Yes		Heart Attack	Yes
Heart Murmur	Yes		Pacemaker	Yes
Rheumatic Fever	Yes		Infective Endocarditis	Yes
Angina (Chest Pain)	Yes		Mitral Valve Prolapse	Yes

If you answered yes to any of these, please explain: ____

Does your child have a Respiratory Diseases / Lung Disorder	Yes		No	
Asthma	Yes		Persistent Cough	Yes
Breathing Difficulty	Yes		Shortness of Breath	Yes
COPD	Yes		Sleep Apnea	Yes

Cont. HEALTH HISTORY (CONFIDENTIAL)

Does your child have special needs?	Yes	No	
ADHD	Yes	Wheelchair	Yes
Behavior Disorder	Yes	Hearing Impairment	Yes
Autism	Yes	Head Injury	Yes
Depression	Yes	Developmental Challenges	Yes
Down Syndrome	Yes	Nervous Disorder	Yes
Cerebral Palsy	Yes	Psychological Disorders	Yes
Vision Impairment	Yes	Bipolar Depression	Yes
Spina Bifida	Yes		

Does your child have an infectious Disease?	Yes	No	
HIV/AIDS	Yes	STD'S	Yes
Hepatitis	Yes	Tuberculosis	Yes
Herpes	Yes		

If you answered yes to any of these, please explain ______________________________

Does your child have Stomach Problems?	Yes	No	
Reflux	Yes	Ulcers	Yes

Does your child have Ear Problems?	Yes	No	
Ear Tubes	Yes	Recurrent Ear Infections	Yes
Hearing Loss	Yes		

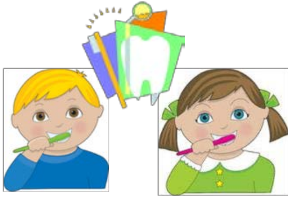
If you answered yes to any of these, please explain ______________________________

Does your child have / had Cancer?	Yes	No	
Chemotherapy	Yes	Remission	Yes, How Long
Radiation	Yes	Leukemia	Yes
Tumors	Yes		

If you answered yes to any of these, please explain ______________________________

Does your child have history of any of the conditions listed below?	Yes	No	
Arthritis	Yes	Liver Disease	Yes
Cleft Palate	Yes	Pregnancy	Yes
Diabetes	Yes	Seizures	Yes
Dialysis	Yes	Sinus Problems	Yes
Epilepsy	Yes	Stroke	Yes
Dizziness/ Fainting	Yes	Tobacco Use	Yes
Joint Replacement	Yes	Drug Use	Yes
Kidney Disease	Yes	Eating Disorder	Yes
Thyroid Disease	Yes	Skin Rash	Yes

Does your child have anything that was not mentioned?	Yes	N



POLICY SHEET PATIENT INFORMATION

Last Name ______________________________ **MI** _____ **First Name** __________________________

SS# ____________________________ **Date of Birth** ________________ **Age** _________________

MISSED APPOINTMENT:
I understand there will be a charge of $25 per child for missed or re-scheduled appointments without a 24 hour notice. I also acknowledge and agree that any fees incurred due to missed appointments must be paid before my child can receive further treatments/cleanings.

PAYMENT POLICY:
I understand that payment is due at the time services are rendered. Any co-payments/deductibles must be paid the day of my child's appointment. I also acknowledge and agree that payment in full is required if my insurance cannot be verified prior to my child being seen.

FLOURIDE TREATMENTS:
I have been advised that my child will receive a fluoride treatment at every cleaning appointment unless otherwise requested differently by me as the parent/guardian. I also understand that if I chose not to have fluoride on my child that it is my responsibility as the parent to let the hygienist know before cleaning begins! I also acknowledge and agree it is my responsibility to know your insurance coverage and if fluoride or other treatments given in this office are a covered benefit under my insurance plan for each visit.

NITROUS (N20):
I understand that for the safety of my child, if he/she has eaten or drinking 1 hour before appointment, we will have to re-schedule my child's appointment for another day.

X-RAYS:
I understand that if I am coming in from another office, it is my responsibility to inform COLLEYVILLE CHILDREN'S DENTISTRY staff of any x-rays that were taken at other dental offices. I understand that it is my responsibility to know my insurance coverage and if x-rays are a covered benefit under my insurance at time of visit(s).
I understand that any x-rays taken are the property of COLLEYVILLE CHILDREN'S DENTISTRY and originals must be kept in THE office for 10 years. I understand and agree that

should I leave COLLEYVILLE CHILDREN'S DENTISTRY and need copies of my child’s x-rays that there will be a $25 per child non-refundable duplication fee and that the x-rays will only be released at my request to another dental office. I also understand that the release could take up to 3 weeks to be sent to the new provider and that my child’s account balance has to be zero in order for x-rays to be released.

INSURANCE:
I understand that it is a courtesy and not a requirement of COLLEYVILLE CHILDREN'S DENTISTRY to file with my primary insurance on behalf of my child/ children. I acknowledge and agree that it is ultimately my responsibility as the parent to know what my plan covers and any unpaid balances not covered by insurance is my responsibility. I understand that COLLEYVILLE CHILDREN'S DENTISTRY will only file my primary insurance and it is my responsibility to file any secondary insurances on my own.

PARENT/GUARDIAN REPONSIBILITY:
I understand that I as the parent am responsible for my child while under the care of COLLEYVILLE CHILDREN'S DENTISTRY. I understand that should I allow someone other than myself to bring my child to his/her appointment that any documents signed by that person or verbal acknowledgments given by that person is ultimately my responsibility and will fall back upon me.

MEDICAL RELEASE
I give permission to my Physician or Health Provider to provide health care information regarding my child(ren)(listed above) to the dentists and staff at COLLEYVILLE CHILDREN'S DENTISTRY.

WEB RELEASE
I give permission for the use of my child(ren)’s first name and picture: in the office, on the website and/or other advertising promotional purposes.

FOR CHILDREN 18 AND OVER (IF APPLICABLE)
I hereby authorize my child(ren) (ages 18 and above) to receive dental treatment (e.g. dental checkup, emergency visits, x-rays, cleaning, fluoride and/or treatment) without an authorized person accompanying him/her.

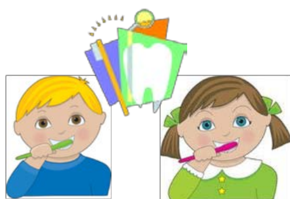
____ ____________________________________

Signature of Patient, Parent, Guardian or Legal Representative **Date**

____ __________________________

Please Print Name of Patient, Parent, Guardian or Legal Representative **Relationship to Patient**

______I, the responsible party, understand payment is due in full at time of treatment unless prior arrangements have been approved by the office manager.



PATIENT PRIVACY FORM

PATIENT INFORMATION

Last Name ______________________________ MI ______ First Name __________________________
SS# ____________________________ Date of Birth _________________ Age __________________

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

COLLEYVILLE CHILDREN'S DENTISTRY is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT
We may disclose your health information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

PAYMENT
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

EMERGENCIES
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS
We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS
We may disclose your health information to coroners or medical examiners.

ORGAN DONATION
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Parent/Guardian Signature: ____
Date ________________________

DENTAL HISTORY (CONFIDENTIAL)

Previous Dentist:

Address:

Date of last dental visit? ______________________

Were x-rays taken? Y / N

If so, what type?

DENTAL HISTORY, CONT.

Has your child injured head, mouth or teeth?

Y / N

If yes, please explain:

Is your child's water fluoridated? Y / N

Does your child take fluoride supplements? Y / N

DENTAL HISTORY, CONT.

Has your child had difficulty with previous dental visits? Y / N

If so, please explain:

Are you aware of any problems with your child's mouth or teeth? Y / N

If so, please explain:

Has your child ever pre-medicated for dental treatment? Y / N

If so, please explain:

COMMENTS/QUESTIONS/CONCERNS