CHILDREN'S DENTISTRY & ORTHODONTICS
WE MAKE SMILES

Patient Health History Form

Today's Date: _____

Patient Information

First Name:	Middle initial:	Last Name:	
Birth date:	Gender:	Nickname:	
Address:	City:	State:	Zip:

Whom may we thank for referring you to our practice? ☐ Friend ☐ Google ☐ Pediatrician ☐ Sign ☐ Other:

IF NEW: Previous Dentist Name / Dental Office Name:

Family History

Parent 1: _____

SSN: _____

Date of Birth: _____

Street Address: _____

City / State / Zip: _____

Main phone #: _____

2nd phone: _____

Relationship to patient: _____

Email: _____

Parent 2: _____

SSN: _____

Date of Birth: _____

Street Address: _____

City / State / Zip: _____

Main phone #: _____

2nd phone: _____

Relationship to patient: _____

Email: _____

Dental History

Any dental concerns:

Injury to face, jaw, or mouth YES / NO	Discomfort from teeth or gums YES / NO	Grind or clench teeth YES / NO	
Mouth breathing YES / NO	Requires antibiotic premedication YES / NO	Swelling in oral cavity YES / NO	Dental anxiety YES / NO

If any of the above dental questions were answered "Yes," please explain:

Medical History

Physician name and name of physician's office: _____

List any medications currently being taken by the patient: _____

Circle all medical conditions that apply to the patient

Rheumatic Fever
Heart Attack, Stroke
Heart Disease
Congenital Heart Defect
Heart Murmur or Heart defects
Tuberculosis/Lung Disease
Pneumonia
Asthma or Other Respiratory Issues
Liver Disease
Kidney Disease
Hepatitis
Latex/ Metal Allergy or Food (peanut) Allergy: _____
Allergy to medicines: Penicillin, Sulfa, List others: _____
Hemophilia
HIV/AIDS
Hypertension, High Blood Pressure
Prolonged Bleeding, Transfusion

Anemia, Iron Deficiency, Sickle Cell
Cancer History/ Radiation or Chemotherapy (past or current)
Nervous System Disorder
Bone Disorders/Bone Loss
Endocrine Problems or taking growth hormones
Diabetes
Seizures, Epilepsy
Physical Handicaps, Disabilities
MTHFR gene mutation
Arthritis, Autoimmune Problems
Special Needs, Autistic
Tonsils, Adenoids Removed
Hearing and vision impairments
Acid reflux
Pregnancy
Describe any other conditions: _____
Initial here, if none apply: _____

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www.wemakesmilesva.com

I authorize the dentists of Children's Dentistry and Orthodontics and such assistants as they may designate to treat minor(s) in my legal custody including stepchildren or myself of legal age using procedures including restorative, oral surgery, and patient management techniques that are reasonable, necessary and deemed advisable by the doctors. I understand that this treatment may include examinations, administration of medications like local anesthetic, restorative, and/or therapeutic dental procedures.

I further consent to taking of clinical photographs and/or radiographs for diagnosis and treatment, healthcare operations and/or payment purposes. I authorize the release of any relevant and necessary patient and clinical information such as x-rays to file a dental claim to insurance providers.

I understand that I am financially responsible for all services rendered regardless of insurance coverage. I authorize payments directly to the dentists of Children's Dentistry and Orthodontics. **I understand that my insurance policy is a contract between my insurance company and me, and that I am responsible to Children's Dentistry and Orthodontics for any charges not covered by insurance, including co-payments, deductibles, and fees for non-covered or denied services.** As a courtesy, Children's Dentistry and Orthodontics will file claims with your dental insurance following the date of service; however, the responsible financial party is fully responsible for all fees regardless of insurance coverage. The office requests Payment in Full on both the patient and insurance portion after sixty days have lapsed from the date of filing. If it is necessary to follow up on my insurance claim due to no payment, I realize this is my responsibility, not the doctors or the practice. If all charges are not paid within 120 days, and my account is referred to collections, I agree to pay the balance from services rendered plus all costs of collection, including collection agency and attorney fees in an amount of thirty-three and one-third (33 1/3%) of the balance placed with the agency and/or attorney.

I understand that as the undersigned who consented to treatment, I will be recognized as 'responsible financial party' and am solely responsible for obligations regardless of insurance coverage and custody arrangements. _____
Initial:

Insurance filing on your(s) or a patient's behalf is a courtesy. We reserve the right to decline to file more than three insurances per patient for any individual claims. Failure to update our practice on insurance changes or timely responses to supplemental insurance questionnaires; and/or contacting your human resources department for nonpayment on covered services will result in the insurance balance being transferred to the responsible party for payment.

Once payment has been received from my insurance company, any balance remaining on my account will be payable by me upon receipt of my statement. Co-payments and other self-pay amounts are due prior to leaving the practice. I have been informed that a fee of $25.00 may be applied to my account for any returned checks. The returned check fee is only payable in cash or by money order.

For patient and staff safety, Our office(s) may be equipped with audio/visual cameras in treatment areas, waiting rooms, and at the reception desks.

I permit a copy of this authorization to be used in place of the original. (This applies to any request from my insurance carrier).

I certify that I was offered a copy of the Health Insurance Portability and Accountability Act (HIPAA) form that is a federal law that protects sensitive patient health information.

Signature: _____ Date: _____