



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? <input type="checkbox"/> Friend <input type="checkbox"/> Google <input type="checkbox"/> Pediatrician <input type="checkbox"/> Sign <input type="checkbox"/> Other:			

Family History

Parent 1: _____ SSN: _____ Date of Birth: _____ Street Address: _____ City / State / Zip: _____ Main phone #: _____ 2 nd phone: _____ Relationship to patient: _____ Email: _____	Parent 2: _____ SSN: _____ Date of Birth: _____ Street Address: _____ City / State / Zip: _____ Main phone #: _____ 2 nd phone: _____ Relationship to patient: _____ Email: _____
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Dental History

If NEW: Previous Dentist Name / Dental Office Name: _____			
Injury to face, jaw, or mouth	YES / NO	Discomfort from teeth or gums	YES / NO
Mouth breathing	YES / NO	Requires antibiotic premedication	YES / NO
		Swelling in oral cavity	YES / NO
		Grind or clench teeth	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: _____ _____
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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 financially 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 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: _____



Dental Insurance Information

Primary Insurance Information

Policy holder name: _____

Policy holder SSN: _____

Employer: _____

Relationship to patient: ☐ Mother ☐ Father ☐ Stepparent ☐ Guardian

Insured Birth Date: _____

Ins. Company: _____

Address: _____

City, State, Zip: _____

Member or Alt #: _____

Group #: _____

Secondary Insurance Information

Policy holder name: _____

Policy holder SSN: _____

Employer: _____

Relationship to patient: ☐ Mother ☐ Father ☐ Stepparent ☐ Guardian

Insured Birth Date: _____

Ins. Company: _____

Address: _____

City, State, Zip: _____

Member or Alt #: _____

Group #: _____

****Responsible/Financial Party Disclaimer:** ** This refers to the individual who signs the medical consent form. If you have a custody/verbal arrangement where another person assumes all or partial financial responsibility for your child, Children's Dentistry & Orthodontics will **NOT** seek payment on your behalf. It will be solely your responsibility to ensure that all or partial payments are made and accounted for. Initials: _____