Brink & White
Pediatric Dental Associates

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PATIENT INFORMATION

Patient's full name: ________________________________Preferred name: ___________Sex: M F Birthdate: ________Age: ____

School: ______________________Grade: ______Child's hobbies/interests/activities: ______________________________________

Is this your child's 1st dental visit? ________If not, when was your child's last dental visit? __________________________________

Purpose of today's visit: _____________________________How did you hear about us? ____________________________________

With whom does the patient live? _____________________ Siblings seen as patients: ______________________________________

Child's physician: ______________ Physician's phone number: ___________________Name(s) of pet(s): _____________________

Whom may we contact (outside of your household) in case of an emergency? Name of Contact: ___________________________

Relationship to patient: ____________________Phone number: __________________Address: ____________________________

PATIENT'S HEALTH HISTORY

Please check the appropriate box (yes or no):

	Yes	No
• Is your child in good health?	☐	☐
• Does your child have regular medical exams?	☐	☐
• Are your child's immunizations current?	☐	☐
• Is your child high strung or nervous?	☐	☐
• Has your child had a toothache lately?	☐	☐
• Has your child ever had surgery or been hospitalized since birth? If yes, please explain________________________	☐	☐
• Has your child ever had an unfavorable medical or dental visit? If yes, please explain________________________	☐	☐
• Is your child undergoing medical treatment for a current or previous condition? If yes, please explain________________________	☐	☐
• Is your child currently taking any medication(s)? If yes, please list______________________________	☐	☐
• Does/did your child thumb suck, finger suck, or use a pacifier? If yes, for how long? _________________________	☐	☐
• Was your child bottle fed past age one?	☐	☐

Please check any applicable boxes:

☐Asthma
☐Autism
☐Down Syndrome
☐Cerebral Palsy
☐Hepatitis
☐Diabetes
☐Developmental Delay
☐Sickle Cell Anemia
☐Lung Problems
☐Epilepsy
☐Seizures
☐Rheumatic Fever
☐AIDS
☐Allergy Shots
☐Food Allergies___________________________
☐Allergies to medicine/drugs_______________
____
☐Adverse reactions to medicine/drugs________
____
☐Heart Condition, explain _________________
☐Other health concerns___________________

☐Vision Disorder
☐Hearing Disorder
☐Speech Disorder
☐Emotional Disorder
☐Thyroid Disorder
☐Liver Disorder
☐Kidney Disorder
☐Blood Disorder
☐Blood Transfusion
☐Tuberculosis
☐Born Prematurely
☐Anxiety
☐Brain Injury

RESPONSIBLE PARTY/CONSENT FOR TREATMENT

The Parent or Legal Guardian who brings the child/children to our office and signs this paperwork will be assigned as Responsible Party on the account. If the signee is not the custodial parent, to be acknowledged as a Legal Guardian for a patient and therefore Responsible Party, legal documents must be presented to our office, stating this arrangement. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the front office staff. If the account balance is not paid within 90 days of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. A Parent/Legal Guardian must remain in the office during dental treatment. Patients 16 years and older can be seen without a Parent/Guardian present, **if prior arrangements are made**. By signing as the Parent/Legal Guardian, you are hereby granting authorization for the doctor to accomplish necessary dental treatment.

Signed____ **Date**____________________________________
Responsible Party/Legal Guardian

PARENT/LEGAL GUARDIAN INFORMATION

PARENT/LEGAL GUARDIAN 1

Name ____

Date of Birth ______________________________________

Address ____________________SS# _________________

City, State, Zip_____________________________________

Home Phone______________ Cell____________________

Employer ___________________Phone _______________

E-mail____

Relationship to Patient______________________________

PARENT/LEGAL GUARDIAN 2

Name____

Date of Birth____

Address_________________________ SS#_______________

City, State, Zip _______________________________________

Home Phone________________ Cell____________________

Employer______________________ Phone________________

E-mail____

Relationship to Patient__________________________________

DENTAL INSURANCE INFORMATION

This office is happy to cooperate with families who are covered by dental insurance. However, we have **no direct relationship with your insurance company**. We will file your claim with your insurance company on your behalf but we assume no financial responsibility if **your** insurance company does not pay as estimated. It is your responsibility to contact your dental insurance company to settle any unpaid/rejected claims. Our office will notify you by sending you a statement and payment of the account is expected within 30 days.

Is your child covered by dental insurance? Yes ☐ No ☐

Primary Insurance Information:

Policy Holder's Relationship to Patient: ______________________

Employee's Name____________________ SS#_______________

Member ID#_______________________DOB _______________

Employer's Name____

Employer's Phone Number__________________________________

Insurance Company ______________________________________

Ins. Co. Phone Number ___________________________________

Address____

Secondary Insurance Information:

Policy Holder's Relationship to Patient: ___________________

Employee's Name________________SS#_________________

Member ID#___________________DOB__________________

Employer's Name_______________________________________

Employer's Phone Number________________________________

Insurance Company_____________________________________

Ins. Co. Phone Number__________________________________

Address____

I hereby authorize assignment of my insurance rights and benefits directly to the provider of services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. I have read and understand my responsibility to settle claims with my insurance company.

Signed____ **Date**_____________________________

Responsible Party/Legal Guardian

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- ❖ Conduct, plan, and direct my treatment and follow up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- ❖ Obtain payment from third party payers.
- ❖ Conduct normal health care operations, such as quality assessments and physician certifications.

I have reviewed your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time. Furthermore, I realize that I may contact this organization at any time at the published address to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signed____ **Date**______________________________

Responsible Party/Legal Guardian

CONSENT TO COMMUNICATE TO A NON-PARENT

It is Patient/Parent's request that the practice communicate with a family representative on behalf of the parents/guardians.

Patient Name (print):____

Patient Name (print):____

Patient Name (print):____

Patient Name (print):____

The following person(s) may attend visits and receive information regarding: check all that apply

❑ Treatment scheduled to be performed

❑ Future treatment planned for the above named child or children

Person Authorized____Relationship____________________________

Person Authorized____Relationship____________________________

❑ This authorization only valid for ________________________________Date(s) of Service

❑ This authorization valid for any dates of service

Signature of Patient/Parent:____Date:____________________

Relationship to the Patient:____

May we email you? YES _______ NO _______ If yes, what email address?____

May we text you? YES _______ NO _______ If yes, what cell number?____

CANCELLATION/CHANGED APPOINTMENT POLICY

A 24 hour notice is required to cancel or change your appointment. If the required 24 hour notice is not provided the following failed appointment fee will be applied to your account:

Routine cleaning appointment	$35.00
Restorative appointment	$50.00
Sedation appointment.	$75.00

This Failed Appointment fee is not covered by your insurance. ***Three or more*** failed appointments could result in your family's dismissal from the practice. If the office is closed, please observe the 24 hour notice requirement by leaving a detailed message. We understand that many emergencies can occur so please notify the Team Member you speak with of your special circumstances.
Remember, keeping your child's dental appointments is in the best interest of your child's health. Progression of existing decay may result in abscess formation that could progress to the point of requiring hospitalization. We want to help your child before this happens. Thank you for your cooperation!

Signed____ **Date**______________________________________

Responsible Party/Legal Guardian

FINANCIAL AGREEMENT

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the front office staff. If the account balance is not paid within 90 days of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the health, insurance, and financial information I have provided.

Signed____ **Date**______________________________________

Responsible Party/Legal Guardian