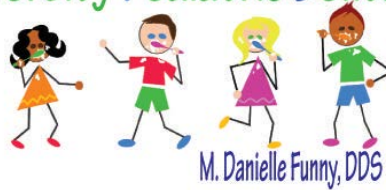

Patient's Name: ___________________________________

Medical History

Has your child ever had any of the following medical problems? Please circle below

Seasonal Allergies	Y N	Seizures/Epilepsy	Y N	Thyroid Problems	Y N
Anemia	Y N	Diabetes	Y N	Mental Disorder	Y N
Asthma	Y N	Drug/Alcohol Abuse	Y N	Nervous System Disorder	Y N
Bleeding Disorder	Y N	Fainting	Y N	Rheumatic Fever	Y N
Bronchitis	Y N	Handicap/Disabilities	Y N	Speech Disorder	Y N
Cancer/Chemotherapy	Y N	Hearing Impairment	Y N	Tuberculosis	Y N
Cerebral Palsy	Y N	Hepatitis	Y N	Tumors/Growths	Y N
Congenital Heart Defect	Y N	HIV/AIDS	Y N	ADD/ADHD/ODD	Y N
Heart Murmur	Y N	OCD	Y N	Kidney Problem	Y N
Teeth Grinding	Y N	Autism/Aspergers/PDD	Y N		

If yes to any above please explain____

Has your child experienced any other physical or mental disorder that is not listed above? Yes No
If yes, please describe: ____

Is your child allergic to any of the following drugs?
Y N Penicillin or Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes No If yes, please list_________________________________

Is your child allergic to latex, red dye, eggs or anything else we should be aware of? Yes No
If yes, please list____

Is your child presently under the care of a physician for any illness? Yes No
If yes, please explain____

List all drugs or medicines presently being taken:____

Has your child ever been hospitalized? Yes No
If yes, please give reasons and date(s)____

May we request the release of your child's medical records if necessary? Yes No

Dental History

Why did you bring your child to see us today?____

Is this your child's first visit to the dentist? Yes No

Has your child ever had a difficult experience with previous dental treatment? Yes No
If yes, please explain____

Date of last dental visit_______________ Name of Dentist__________________________________

For what service_______________________

Were any x-rays taken? Yes No
If yes, have x-rays been sent to our office?___________________ Date requested_______

How do you expect your child to behave in our office?____

Do you assist child with brushing? Yes No

Does your child take any type of fluoride supplement? Yes No

Any injuries to mouth, teeth, head? Yes No Date(s) _____________

If there is any information that you feel might be of value to us in the treatment of your child, please add it here:
____

____

I give my consent for dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name)____.
I accept responsibility for payment of services rendered.

Signature (Parent/Guardian)____

Today's Date ___________________________

Reviewed by Dr. Funny / Dr. Maynor _________

Patient Information

Patient's Name ______________________________________ Name child goes by __________ Sex____
(First) (Middle) (Last)

Mailing Address____
(Street) (City) (State) (Zip)

Date of Birth:________________ Age:_____ Weight_____

Child lives with: Both Parents _____Mother_____Father_____Other______________________________

Patient's Physician or Pediatrician's Name____________________ Family Dentist__________________

Names of Siblings:

Child's Name ___________________________________ DOB ___________ Age _______
Child's Name ___________________________________ DOB ___________ Age _______

How did you hear about us :____

E-mail address: ____

Responsible Party Information

Mother
Name ____ Marital Status____________

Social Security No. __________________ Birth date _________ Employer______________________

Address if different from above____

Phone: Home __________________ Work ____________________ Cell _____________________

Father
Name ____ Marital Status____________

Social Security No. __________________ Birth date _________ Employer______________________

Address if different from above____

Phone: Home __________________ Work ____________________ Cell _____________________

Dental Insurance Information

Primary Insured's Name ____________________________ Insured's Soc. Sec. No. ________________

Insured's Birth date _____________ Primary Insured's Employer_________________________________

Insurance Co._________________ Insurance Co address____

Subscriber No.__________________ Group No. ____________Insurance Co. Phone no.______________

I hereby authorize payment of the dental benefits otherwise payable to me directly to University Pediatric Dentistry.

Signed Employee/Subscriber____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ___________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

___________________________________ ___________________________________

Please ***print*** name of Patient — Please ***sign*** for Patient / Guardian of Patient

___________________________________ ___________________________________

Legal Representative / Guardian — Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ____

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other ____________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ___________________________ Relationship: _______________________________

Name: ___________________________ Relationship: _______________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to My Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to My Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

☐ Phone Message ☐ **Any of the Above**
☐ **None of the above** (opt out)
☐ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) ____ ____

Signature of Privacy Officer

HIPAA made EASY™
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