New Patient Packet

Date___________________

Patient's name ____

Last First Middle

Address ____

Street City Zip

Nickname______________________ Birthdate_______________ Social Security # ________________________

School Currently Attending: ____

Whom may we thank for referring you to our office? ________________________________

RESPONSIBLE PARTY INFORMATION

Name ____

Last First Middle

Residence ____

Street City Zip

Mailing Address ____

Street City Zip

How long at this address? ______ Home phone_________________________ Work phone__________________________

Cell/other phone_________________________ Email address____________________________________

Social Security #_____________________________ Birthdate_________________ Relationship to Patient _____________________

Employer_____________________________________ Occupation____________________ No. years employed ________________

Spouse's Name____ Relationship to Patient_________________________

Employer_____________________________________ Occupation____________________ No. years employed ________________

Social Security # ________________________________ Birthdate_____________________ Work Phone______________________

EMERGENCY INFORMATION

Name of nearest relative not living with you ____________________________________

Complete address ____

Street City Zip

Phone ____

MEDICAL INSURANCE INFORMATION

Policy Holder's Full Name____ Policy Holder's Relation to Patient: ___________________

Insured's Social Security ______________________________ Policy Holder's Date of Birth: ___________________________________

Policy Holder's Mailing Address: ____

Insurance Company__________________________ Group No.__________________ Subscriber ID No. __________________________

Insurance Co. Address____ Phone No.________________________________

Do you have dual coverage? Yes_____ No_____ If yes:

Policy Holder's Full Name____ Policy Holder's Relation to Patient: ___________________

Insured's Social Security ______________________________ Policy Holder's Date of Birth: ___________________________________

Policy Holder's Mailing Address: ____

Insurance Company__________________________ Group No.__________________ Subscriber ID No. __________________________

Insurance Co. Address____ Phone No.________________________________

DENTAL INSURANCE INFORMATION

Policy Holder's Full Name____ Policy Holder's Relation to Patient: ___________________

Insured's Social Security ______________________________ Policy Holder's Date of Birth: ___________________________________

Policy Holder's Mailing Address: ____

Insurance Company__________________________ Group No.__________________ Subscriber ID No. __________________________

Insurance Co. Address____ Phone No.________________________________

Do you have dual coverage? Yes_____ No_____ If yes:

Policy Holder's Full Name____ Policy Holder's Relation to Patient: ___________________

Insured's Social Security ______________________________ Policy Holder's Date of Birth: ___________________________________

Policy Holder's Mailing Address: ____

Insurance Company__________________________ Group No.__________________ Subscriber ID No. __________________________

HEALTH HISTORY

Patient Name:	Date of Birth:
Primary Care Physician (name and phone number):	

Heart	☐ Heart Murmur ☐ Mitral Valve Prolapse ☐ Congenital Heart Defect ☐ Heart Surgery ☐ Low/High Blood Pressure ☐ Rheumatic Fever ☐ Other (not listed) ***Please Explain***: ______
Kidney	☐ Bladder ☐ Urinary Problems ☐ Other ***Please Explain***: ______
Liver / GI	☐ Reflux (GERD) ☐ Stomach/Intestine Ulcers ☐ Gastritis ☐ Colitis ☐ Diarrhea ☐ Jaundice ☐ Hepatitis ☐ Liver Disease ☐ Other (not listed) ***Please Explain***: ______
Endocrine	☐ Diabetes Type: ______ ☐ Thyroid Disease (Hyper/Hypo) ☐ Other (not listed) ***Please Explain***: ______
Hematologic	☐ Anemia ☐ Hemophilia ☐ Leukemia ☐ Sickle Cell Disease / Trait (circle) ☐ Prolonged Bleeding ☐ Blood Transfusion (latest date: ______ / Started: ______) ☐ Other (not listed) ***Please Explain***: ______
Lung / Respiratory	☐ Asthma ☐ Allergies/Hives ☐ Sinus Trouble ☐ Chronic Cough ☐ Hay Fever ☐ Tuberculosis ☐ Other ***Please Explain:*** ______
Neurological	☐ ADHD ☐ Autism ☐ Developmental Delay ☐ Speech Disorder ☐ Nervous Disorder ☐ Mental Disorder ☐ Down Syndrome ☐ Cerebral Palsy ☐ Seizures/Epilepsy ☐ Fainting ☐ Headaches ☐ Brain Injury ***Please Explain***: ______
Hearing / Vision	☐ Vision Problems ☐ Glaucoma ☐ Earaches ☐ Hearing Loss ☐ Other (not listed) ***Please Explain:*** ______
Dermal / Musculoskeletal	☐ Latex Allergy ☐ Eczema ☐ Rashes ☐ Fever Blisters/Cold Sores ☐ Other (not listed) ***Please Explain***: ______

Does your child have any disease, condition or other health problems not listed above? If yes, please explain:	☐ Yes	☐ No
Medications (names and dosages): Please list ALL taken, including vitamins & supplements	☐ Yes	☐ No
Does your child have any allergies to food or medications? If yes, please list:	☐ Yes	☐ No
Has your child been hospitalized overnight since birth? If yes, when? Why?	☐ Yes	☐ No
Has your child ever had any surgery? If yes, when? Why?	☐ Yes	☐ No
Has your child had any radiation or chemotherapy? If yes, when? Why?	☐ Yes	☐ No
Does your child use tobacco?	☐ Yes	☐ No
Does your child have AIDS or has he/she been tested HIV-positive?	☐ Yes	☐ No
Is your child adopted? If yes, does he/she know?	☐ Yes	☐ No
Females: any possibility of pregnancy?	☐ Yes	☐ No

______ PARENT/GAURDIAN SIGNATURE ______ PRINTED NAME ______ (RELACTIONSHIP TO PATIENT) ______ DATE

DOCTOR SIGNATURE: ______ DATE:______

Dental History

What is your primary concern about your child's oral health?	
How would you describe: your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor your oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor	
How often does your child brush his/her teeth? ______ times per ________. Does someone help? How often does your child floss his/her teeth? ______ times per ________. Does someone help?	☐Yes ☐ No ☐Yes ☐ No
Have there been any injuries to teeth, such as falls, blows, or accidents? When? Please describe: ____	☐Yes ☐ No
How frequently does your child have the following? Candy or other sweets: ☐Rarely ☐1-2 times/day ☐3+ times/day Product ______________________ Chewing gum: ☐Rarely ☐1-2 times/day ☐3+ times/day Type ______________________ Snacks between meals: ☐Rarely ☐1-2 times/day ☐3+ times/day Usual snack ______________________ Soft drinks* ☐Rarely ☐1-2 times/day ☐3+ times/day Product ______________________ (*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks) Please note other significant dietary habits: ______________________________________ ____	
Has your child had any dental treatment completed in the past? When? ____________________ If yes, describe: ____	☐Yes ☐ No
Has your child had any difficult dental experiences in the past? If yes, describe: ____	☐Yes ☐ No
Does your child currently have any cavities?	☐Yes ☐ No
How do you expect your child will respond to dental treatment? ☐ Very well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly	

Is there any additional information that we should know before treating your child? ☐Yes ☐ No
If yes, describe:

Is there any additional information that we should know before treating your child? ☐Yes ☐ No
If yes, describe:

____
____

FINANCIAL POLICIES AND AGREEMENT

Missed Appointment Policy

We work diligently to see all our patients in a timely manner. Missed appointments leave us with holes in our schedule that prevents us from providing timely care for the children in our community. Missed appointments affect everyone. Therefore, we have instituted a "Missed Appointment Policy" which states that **appointments not cancelled within 48 hours minimum advance will be charged a fee of $50.00.** In the event that you miss 3scheduled appointments, we will release patient from the office and be happy to forward patient records to your dental office of preference.

Missed Oral Sedation and Operative Appointments

Due to the high demand for sedation appointments, we have implemented a "Missed Surgical / Operative Appointment Policy" to encourage patients to keep their appointments. If you cannot attend your scheduled appointment, you **must call** a minimum of 72 hours in advance. If we do not have a 72-hour advance notice of cancellation, you will be charged a **$200 non-refundable "Missed Surgical/Operative Appointment Fee"**.

Payment/Insurance Policy

As a courtesy, we file insurance claims for our patients. **All estimated out of pocket portions are due at time of service.** This amount is an estimate of your copayment and we work hard to make this as accurate as possible. **You are responsible for any amount not covered by your insurance.**

Our office accepts cash, check, Visa, MasterCard. We also offer financing through CareCredit and In-House financing.

I understand that I am responsible for the payment for all the fees for dental treatment that are not covered by the patient's dental or medical insurance. The parent or guardian who accompanies the patient to the appointment will be responsible for estimated portions due at the time of treatment, unless prior arrangements have been made. I agree that should the account be referred for collection, I will be responsible for all collections charges including attorney fees.

Parent/Legal Guardian Signature ____ Date ________________

Bend Children's Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

____

Please Print <<Print Your Full Name Here>>

____

Signature

____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_ Individual refused to sign
_ Communications barriers prohibited obtaining the acknowledgement
_ An emergency situation prevented us from obtaining acknowledgement
_ Other (Please Specify)

____

____

Witness: ________________________________

Consent to Treatment

Consent to Examine

It is our policy to keep you informed and involved in your child's dental progress. A typical examination consists of oral hygiene instruction, cleaning of the teeth, application of a topical fluoride, x-rays, and examination of the teeth, hard and soft tissue of the mouth, bite, and jaw. Except in an emergent situation or if existing disease is located, no further treatment will be performed during an examination. However, after the examination, we will create a treatment plan that may include fillings, caps, extractions, etc., and will seek your consent prior to performing the identified treatment. Treatment plans may cover multiple visits and once consent is obtained, we will not seek consent again unless the treatment plan changes. By signing below, you give consent for Bend Children's Dentistry to perform an examination as outlined above. You further certify that you have legal authorization to consent to dental and medical treatment for the patient.

_______________________________ _______________________ ______________

Signature Relationship to patient Date

Alternative Consent (Must be 18 or older)

We recognize that it is not always feasible for the legal parent or guardian to accompany a child to his or her appointment or be available to provide consent for treatment. In an effort for us to ensure that the child is able to continue care, we would like to know if there are others who are authorized to consent to treatment for your child. By signing below, you give authorization for the person(s) listed to consent to recommended medical/dental treatment including, but not limited to, diagnosis, application of topical treatments (fluoride, sealants) x-rays, anesthesia, and invasive dental procedures. This authorization will remain in effect until you notify us in writing of any changes.

Name	Relationship to Patient	Phone Number

_______________________________ _______________________ _______________________

Signature Relationship to patient Date