Child Health/Dental History Form

ADA
American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ❑ F ❑	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

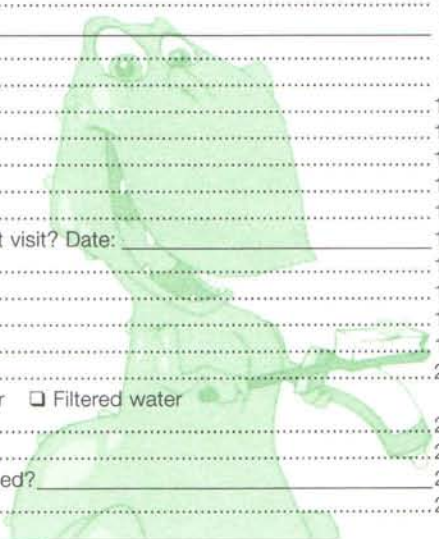
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Greene Comprehensive Family Dentistry

118 Stoneridge Drive, Suite #A
Ruckersville, VA. 22968

Patient Information

Patient Name: _____

Address:_____

City:_____ State:_____ Zip:_____

Home Number: ( ) _____ Work Number: ( ) _____

Cell Number: ( ) _____ Email: _____

Patient SS#: _____ DOB: _____

Drive License #: _____ State of Issue: _____

Financially Responsible Party

Name: _____ Patient Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Number: ( ) _____ Work Number: ( ) _____

Cell Number: ( ) _____ Email: _____

Insurance Information

Policy Holder: _____ Patient Relation: _____

Policy Holder's DOB: _____ Policy Holder's SS#:_____

Policy Holder's Employer:_____ Work Phone Number: ( )_____

Insurance Company:_____ Phone Number: ( )_____

Group #:_____ Subscriber ID #:_____

Emergency Contact Information

Emergency Contact:_____ Phone Number: ( )_____

Address:_____

City:_____ State:_____ Zip:_____

GREENE COMPREHENSIVE FAMILY DENTISTRY

PATIENT FINANCIAL RESPONSIBILITY

I _____ hereby assign to Greene Comprehensive Family Dentistry all payments for all services rendered to myself and/or my dependents. I understand that I am responsible for payment of any amount not paid by my insurance company and that billing my insurance company is a courtesy and not an obligation of this office.

I acknowledge that any insurance claims pending beyond thirty (30) days are my responsibility. I will immediately pay the balance if the account balance is more than thirty (30) days past due. I understand that if I make a payment and Greene Comprehensive Family Dentistry thereafter receives payment from my insurance company, I will be reimbursed. I understand that if my account is still outstanding after sixty (60) days from the date of service(s), my account may be referred to a collection agency or an attorney for collection unless prior agreements are made.

This office participates as "Dental Providers" for **Anthem, Cigna Radius, Delta Dental Premier, Guardian, MetLife** and **United Concordia.** If you have dental insurance with companies other than those listed above, you will be responsible for your co-payment **TODAY** according to your dental insurance plan. We will submit today's visit to your insurance company. Also that all estimates for co-payment are **estimates** you are responsible for what your insurance does not pay.

- I agree to pay interest on the total paid monthly balance at the rate of **18.00% APR**, such interest to begin if the **account is thirty (30) days past due** and calculated from the date of service.
- I agree to pay all costs of collections, including, but not limited to, thirty-five percent (35%) collection fees and attorney fees of thirty-three percent (33%), but not less than $200.00, regardless if suit is filed or not, as well as, all court costs.
- I authorize my employer to release all information regarding employment and salary verification.
- I understand Greene Comprehensive Family Dentistry **DOES NOT** accept postdated checks.
- I understand Greene Comprehensive Family Dentistry **DOES NOT** accept payment plans and payment is expected at every appointment unless otherwise stated.
- Broken, missed, or canceled appointments without 24 hours prior notification will be charged a missed appointment fee of $75.00.
- **I will pay any expected deductible and co-insurance amounts today and at each future office visit.**

We are a medical practice and as such we will ask you to complete a Health History Form. We will ask you for updates of your personal and medical information. Please notify our staff if there is a change in your health. Your health information is important to us and to your treatment here. Your cooperation in completing this information is appreciated.

THERE WILL BE A FEE OF $35.00 FOR ALL RETURNED CHECKS

_____ _____ _____

Print Name (Patient) Signature of Responsible Party Date

GREENE COMPREHENSIVE FAMILY DENTISTRY

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law.
You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Practice is a member of statewide Prescription Monitoring Program.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

I give my permission to discuss my treatment and or billing information with: _____

Relationship to patient (check one):

❽ Spouse ❽ Parent ❽ Child ❽ Grandparent ❽ Grandchild ❽ Legal Guardian

❽ Attorney (or representative) of patient ❽ Other: _____

This HIPAA Consent was signed by: _____ _____

Signature of patient or guardian — Printed name of same

Relationship to the patient (if other than patient):_____ _____

Please print — Today's Date

Signature of practice representative:_____