Child Health/Dental History Form

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:

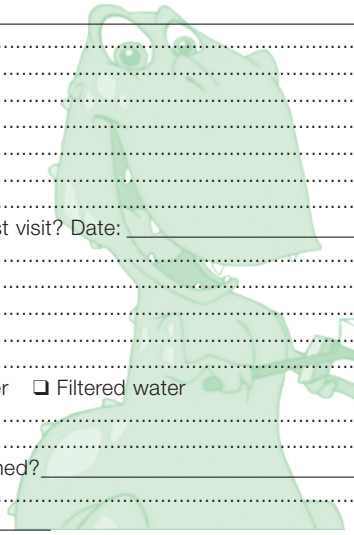
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic 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

Office Policy

please initial each item, and sign below that you have received our office policy, and that all your questions were answered.

_____ I understand and agree that payment of the estimated co-payment is due in full at the time of service unless previous financial arrangements have been made. Payments options are: Credit or Debit Card, Cash, Check, CareCredit.

_____ As a courtesy to our patients, our office will gladly file your insurance for you, given the correct information is provided. Your insurance carrier upon, receipt of the claim, will determine the final benefit calculation. The treatment estimate is not a guarantee of payment or eligibility. We do however request that you pay your estimated portion when services are rendered. **Your insurance is a contract between you and your employer, so we will do our best to get an accurate breakdown of benefits. However, any amount not covered by insurance will be the patient/parent's responsibility.** This includes and deductibles, co-pays, etc.

_____ If my insurance has a preferred provider list and Glazer Family Dentistry is not on that list, I may be responsible for additional out-of-pocket expenses.

_____ I understand that fees quoted in the treatment plan are guaranteed for 120 days. After 120 days, fees are subject to change.

_____ Glazer Family Dentistry has a standard set of fees called the usual, customary and reasonable (UCR) fee schedule. All claims submitted to your insurance company will reflect those UCR fees. If you are covered by a plan that gives you a discounted fee schedule, the discounted fee will be charged to your account and recognized by the insurance carrier upon receipt of the claim.

_____ The parent/guardian who brings the child to their visit is responsible for payment regardless of what a divorce decree may state. Reimbursement must be between the divorced parents or guardians of the child.

_____ Out of respect for patients who have arrived on time for their appointment, **you may be asked to reschedule your appointment if you arrive more than 15 minutes after your scheduled appointment time.**

_____ Please understand that appointment times are limited. If you must cancel or reschedule your appointment, we respectfully request 48-hour notice. **Missed appointments, rescheduled appointments or appointments cancelled without 48 hour notice, will incur a fee of $25.**

Patient/Guardian Print _____ Date: _____

Patient/ Guardian Signature: _____ Date: _____

AUTHORIZATION FOR TREATMENT OF A MINOR (if applicable): ONLY those persons listed below are authorized to bring your child to their dental appointments and receive personal medical and dental information. However, only the legal guardian can provide consent for invasive dental treatment. Regardless of who brings the child, you are still responsible for the financial payments on this account. The legal guardian is responsible for making changes regarding the persons authorized on this form.

Authorized name other than Guardian _____ Relationship to Child _____

Authorized name other than Guardian _____ Relationship to Child _____

FOR PATIENTS 16 YEARS AND OLD (IF APPLICIABLE) I hereby authorize my child (ages 16 and above) to receive his/her dental check-up, x-rays, cleaning, fluoride without an authorize person accompanying him/her.

Accept _____ Deny_____

Patient/Guardian Print _____ Date: _____

Patient/ Guardian Signature: _____ Date: _____

WEB RELEASE: I give permission for the use of my (or my child's) first name and picture, whether alone of with other (family members or friends) for purposes of education, research, publicity, promotion, website, advertising or publication including print, newspaper, printed media, radio, television, website, broadcast and electronic media (eg: our prize winners).

Accept _____ Deny_____

Patient/Guardian Print _____ Date: _____

Patient/ Guardian Signature: _____ Date: _____

glazer family dentistry

Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve while respecting your budget. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Payments are expected at the time services are rendered. We accept cash, checks (under $500.00), debit cards, and all major credit cards.

As a courtesy to our patients, our office will gladly file your insurance for you, given the correct information is provided. We do however request that you pay your estimated portion when services are rendered. **Your insurance is a contract between you and your employer, so we will do our best to get an accurate breakdown of benefits. However, any amount not covered by insurance will be the patient/guardian's responsibility**. This includes any deductibles, co-pays, etc.

Broken appointments: We do not double book our patients. We have reserved your appointment time just for you, so we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **48 hours notice** to avoid a cancellation fee (emergencies are an exception).

Returned Checks: There will be a $25.00 charge for all returned checks.

Patient/Guardian Print _____

Patient/Guardian Signature_____

Date_____

Assignment of Benefits and Authorization Release

I hereby authorize and request my insurance company to assign benefits directly to my dentist or dental group insurance benefits otherwise payable to me. If my current policy prohibits direct payment to dentist, I hereby agree to pay the dentist the sum equal to the insurance payment received by me. I shall mail the check as follows:

Payable to: Brittaney Glazer, DDS PLLC

Mail to: Glazer Family Dentistry

119 N. Murphy Rd #500

Murphy TX 75094

I authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions, and for any information pertinent to my case to any insurance company, adjuster or attorney involved in this case. I authorize the doctor to initiate a complain to the Insurance Commissioner for any reason on my behalf. A photocopy of this Assignment shall be considered as effective and valid as the original.

Signature of Patient/ Guarantor if minor _____ Date _____

PATIENT CONSENT FORM / NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at their 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to patient: _____ Date: _____

For Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

_____ _____ _____

Date Name Reason

Authorization to Disclose Health Information to Family Members and Friends

Patient Name_____ Date of Birth_____/_____/_____

I hereby authorize Glazer Family Dentistry to release my health information as described below:

		Type of Information Allowed to Disclose (Check one or both)		Method to Disclosure (Check one or both)	
Name	**Relationship**	**Medical**	**Billing**	**By Phone**	**In person**

Protected Health Information ("PHI") may include information/documents regarding dental/medical treatment of the patient including, but not limited to, diagnosis, procedures, treatment plans, appointments and test results; account and billing information including, but not limited to, account balances, payments and payment arrangements, insurance claims status, and third party financing.

I understand that the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA") govern the terms of this Authorization. I understand that I have the right to revoke this Authorization, at any time prior to the Practice's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions, the right to revoke and a description of how I may revoke this Authorization is set forth in DDA's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this Authorization and my signature; and that I should send it to the attention of the "HIPAA Compliance Officer".

I understand that I am not required to sign this Authorization and that Glazer Family Dentistry may not condition treatment on my execution of this Authorization.

I understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA. This authorization expires when I am no longer a patient in this practice or have revoked this authorization.

(Check One) I DO____DO NOT____ GIVE PERMISSION to Glazer Family Dentistry, to leave information on my answering machine and/or with my family members in regard to treatment plans, referrals, test results and/or billing and payment information. HIPAA guidelines allow for basic information regarding appointments (time, date, location) to be left on an answering machine or with family members. HIPAA regulations authorize the release of PHI for the purpose of treatment, obtaining payment from third party payers, and the day-to-day healthcare operations of DDA. Other than those releases authorized by HIPAA, PHI will only be released to persons listed on this authorization, If you choose not to authorize any family members or friends for disclosure of PHI, DDA will not be able to release any information, including appointment or patient billing questions to anyone other than the patient.

_____ _____

Signature of Patient or Personal Representative (i.e. Guardian) Relationship of Personal Representative to Patient

Date of Authorization_____