Children's Dental Health
Healthy Smiles Start Here

To help us better serve you, please complete the following forms to the best of your ability.
If you have questions, do not hesitate to let us know. Thank you for choosing our office!

Child's Name: _____ **DOB (MM/DD/YY):** _____

Nickname: _____ **Age:** _____ **Social Security #:** _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined **Gender:** ☐ Male ☐ Female ☐ Other

Race: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Other ☐ Declined

Home Address: _____

City, State, Zip: _____ **Phone Number:** _____

Who can we thank for referring you to us? (Please check all that apply.)

☐ Primary Care Doctor
☐ General Dentist
☐ Friend/Family
☐ School/Daycare

How have you heard about us? (Please check all that apply.)

☐ Social Media
☐ Google/Website
☐ Insurance Directory
☐ Drive-by/Signage
☐ Newspaper/Magazine
☐ School/Daycare
☐ Community Event/Festival
☐ Other

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Mother/Guardian)

Name: _____ **Relationship:** _____

DOB: _____ **Social Security #:** _____ **Email Address:** _____

Home Address (if different than child): _____

City, State, Zip: _____ **Phone Number:** _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Father/Guardian)

Name: _____ **Relationship:** _____

DOB: _____ **Social Security #:** _____ **Email Address:** _____

Home Address (if different than child): _____

City, State, Zip: _____ **Phone Number:** _____

PRIMARY DENTAL INSURANCE:

Insurance Company: _____ **Insured's Name:** _____

Relationship to Patient: _____ **DOB:** _____ **Social Security #:** _____

Employer: _____ **Subscriber's ID:** _____ **Group #:** _____

SECONDARY DENTAL INSURANCE:

Insurance Company: _____ **Insured's Name:** _____

Relationship to Patient: _____ **DOB:** _____ **Social Security #:** _____

Employer: _____ **Subscriber's ID:** _____ **Group #:** _____

FLUORIDE CONSENT

Most insurance companies cover fluoride treatment twice a year; however, some insurance companies only pay for a once-a-year application.

PLEASE CHOOSE ONE (1) OF THE FOLLOWING:

I, _____ give my consent to apply fluoride treatment TWICE a year. I agree that if my insurance company does not pay for the second application, that I am financially responsible for payment.

I, _____ give my consent to apply fluoride treatment only ONCE a year.

I, _____ do not wish fluoride treatment to be applied to my child at any time.

FINANCIAL ARRANGEMENTS/INSURANCE AGREEMENT

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

Any unpaid balance due (as listed on a billing statement), not paid within 28 days of the monthly billing date, will be assessed a late charge of 1.5% each month. I realize that failure to keep this account current may result in my children being unable to receive additional dental services except for dental emergencies or when there is pre-payment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection cost (33% of the unpaid balance), postage, attorney and court fees incurred in attempting to collect on this amount or any future outstanding balances.

I hereby authorize the office to contact the designated phone numbers and/or email address listed in the patient's account. With this authorization, a message/communication may be left indicating appointment time and dates, reminders, balances due, and/or estimated co-pays for future visits.

Financially responsible person for account ☐ Self ☐ Other _____

_____

Signature of Parent or Legal Guardian Date

☐ Child in foster care- Children & Youth and Foster Parents will not sign Staff Initials _____

HEALTH/DENTAL HISTORY

Patient Name: _____ ☐ **Male** ☐ **Female** **Date of Birth:** _____

☐ Parent/Legal Guardian: _____ ☐ Documentation of Court Order on file

☐ Foster Parent: _____ Case worker: _____ Phone Number: _____

Primary Care Physician Name: _____ **Phone Number:** _____

Specialists: Name of Facility/Doctor: _____ **Phone Number:** _____

Name of Facility/Doctor: _____ **Phone Number:** _____

Reason seen by Specialist: _____ **Date last seen:** _____

ALLERGIES: ☐ No Known Allergies ☐ Medications ☐ Food ☐ Seasonal/Environmental ☐ Tape ☐ Latex

Allergy	Reaction

MOTHER/FATHER ALLERGIES: ☐ No Known Allergies ☐ Allergy and reaction: _____

MEDICATIONS: ☐ None taken ☐ Takes Medications (please list below.)

Medication	Dosage	Frequency	Reason

SURGERIES/HOSPITALIZATIONS: ☐ No surgery/hospitalization ☐ Admitted to hospital or had surgery (please describe below.)

Date	Surgery/Hospitalization	Outcome

Anesthesia Problems: ☐ No Known Anesthesia Problems

Has the child or anyone in the family been diagnosed with the following:

☐ Malignant Hyperthermia ☐ Pseudocholinesterase Disease ☐ Severe Postop Nausea/Vomiting

☐ Airway complications: Tracheomalacia/Laryngomalacia

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Hematological System: ☐ No Known Problem with Blood Diseases

☐ Blood diseases _____ ☐ Anemia TYPE? _____ ☐ G6PD

☐ Bleeding tendencies/Factor deficiencies; WHICH FACTOR? _____ ☐ History of Transfusions ☐ HIV/AIDS

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Respiratory System: ☐ No Known Problems with Lungs

☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Sleep Apnea

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Cardiovascular System: ☐ No Known Problems with Heart

☐ High blood pressure ☐ Problem with heart rhythm ☐ Pacemaker ☐ Defibrillator ☐ Stroke

☐ Mitral Valve Prolapse ☐ Murmur ☐ Phlebitis ☐ Problem with heart valves ☐ Congenital heart defect now or at birth

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Nervous System: ☐ No Known Issues

☐ Seizures ☐ Tremors ☐ Vertigo ☐ Cerebral Palsy

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Endocrine System: ☐ No Known Issues

☐ Diabetes ☐ Noninsulin Dependent ☐ Insulin Dependent ☐ Thyroid Disease

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Digestive System: ☐ No Known Issues

☐ Hiatal Hernia ☐ Acid Reflux ☐ Ulcers ☐ Hepatitis ☐ Chronic constipation ☐ Chronic Diarrhea ☐ No bowel control

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Genitourinary System: ☐ No Known Issues

☐ Kidney problems ☐ Bladder Issues ☐ Bed

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Reproductive System: ☐ No Known Issues

Last Menstrual Period _____ ; or ☐ Not Applicable ☐ Ovarian Cysts ☐ Endometriosis

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Skeletal System: ☐ No Known Issues

☐ Arthritis ☐ Neck/Back Problems ☐ Mobility Limitations ☐ Wheelchair-bound ☐ Assistive device: _____

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Psychosocial: ☐ No Known Issues

☐ Mental health disorder ☐ Sleep disorder ☐ Recent life changes/stressors

☐ Late sleeper ☐ Heavy sleeper ☐ ADD ☐ ADHD ☐ Autism

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Skin: ☐ No Known Issues

☐ Psoriasis ☐ Eczema ☐ Bruises Easily

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Infection: ☐ No Known Issues

☐ MRSA ☐ VRE ☐ CDIFF When? _____ Where? _____ Last test performed? _____

** **Office Use ONLY:** ☐ Request for negative culture faxed to PCP ☐ Negative culture received and on file

Other: ☐ No Known Issues

☐ Cancer ☐ Microencephalopathy ☐ Down's Syndrome ☐ Dwarfism ☐ Recent illness ☐ Congenital Anomaly

☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Does patient have: ☐ Glasses ☐ Hearing Aids – L / R ☐ Loose/Capped/Missing Teeth – Upper / Lower ☐ N/A

Exposure to second hand smoke ☐ yes ☐ no

Alcohol abuse in the family ☐ yes ☐ no

Illicit drug use in the family ☐ yes ☐ no

History of physical abuse in the family ☐ yes ☐ no

ADDITIONAL COMMENTS: _____

USE AND DISCLOSURE OF HEALTH/DENTAL INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protection health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may mmake of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact: Practice Manager - Brook Murphy
Telephone: 484-787-2900 **Fax:** 484-698-7848
Email: brook@childrensdentalhealth.com
Address: 200 Willowbrook Lane, Suite 220, West Chester, PA 19382

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of you revocation submitted to the contact person listed above. Please understand the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat your child if you revoke this consent. I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

If this consent is signed by a personal representative on behalf of the patient complete the following:

Patient's Name: _____

Relationship to Patient: _____

Personal Representative's Name: _____

_____

Signature **Date**

Thank you for completing this questionnaire.
We look forward to caring for your child.

YOU ARE ENTITLED TO A COPY OF YOUR PAPERWORK AFTER SIGNED.