Patient Health History

Patient Name_______________________________ Birth date: ____/____/____ Today's Date: ____/_____/______

Child's Physician____ Phone#:______._____._________

Who May We Thank For Referring You?

____

Purpose of Today's Visit:

____

Date of Last Dental Visit: _______/_________/__________ Previous Dentist: _______________________________

Circle One

1. Does your child have any specific medical condition - tuberculosis, cancer, cerebral palsy, etc.?
If so, please specify____ 1. Yes No
2. Does your child have any special limitations either mental or physical?
If so, please specify____ 2. Yes No
3. Has your child ever had an operation?____
If so, please specify____ 3. Yes No
4. Have you ever been told by a physician that your child had/has a heart murmur, rheumatic fever, or a shunt?
At what age_____ Was a cardiogram ever done? _____ Is antibiotic coverage needed for dental work?_____ 4. Yes No
5. Does your child have asthma or breathing problems? 5. Yes No
6. Does your child have a history of seizures? 6. Yes No
7. Has your child ever tested positive for Hepatitis or HIV? If so, please specify____________________________ 7. Yes No
8. Does your child have any allergies to Antibiotics 8. Yes No
Analgesics (aspirin, codeine) Yes No
Latex Yes No
Pollen, Grass, Dust Yes No
9. Is your child now taking any medicine? If so, please specify____ 9. Yes No
10. Does your child have any learning disabilities, ADD or ADHD? If so, please specify_____________________ 10. Yes No
11. Has your child ever had a transfusion of whole blood or any blood products? __________________________ 11. Yes No
12. Does your child have any social difficulties? 12. Yes No
13. Is your child adopted? 13. Yes No
14. Is your child in foster care? 14. Yes No
15. Are parents separated, divorced, widowed or never married? (Question asked to aid in our understanding of emotional status of child) 15. Yes No
16. Has your child had a history of thumb sucking, finger sucking, lip sucking, pacifier use or nail biting?
If so, please explain____ 16. Yes No
17. Was your child's pregnancy or delivery abnormal in any way? 17. Yes No
18. Was your child breast fed?______ Bottle fed?_______ Any difficulties? ______________________________ 18. Yes No
19. Has your child ever had a prolonged fever for any reason? 19. Yes No
20. Has your child ever had any unfavorable experience in a medical or dental office? 20. Yes No
21. Has your child ever had any injuries to the teeth, mouth, head or neck?
If so, please explain____ 21. Yes No
22. Has the child's natural parents ever had extensive tooth decay? 22. Yes No
23. Does your child brush his/her teeth at least twice per day? 23. Yes No
24. Has your child had a toothache lately? _______ If yes, was the toothache after eating? _______
Did it awaken the child from sleep? __________ 24. Yes No
25. How do you think your child will react to this dental visit?
Very poor? ______ Poor? ______ Well? ______ Very Well? ______ 25.
26. Are there any other conditions or concerns not listed here?
If so, please specify____ 26. Yes No

____ Date: ____/____/_____
Signature of Parent or Guardian

New Patient Form

YOUR CHILD/CHILDREN

Name	Nickname	Birthdate	Gender
____	__________	__________	_________
____	__________	__________	_________
____	__________	__________	_________

Home Address:____

City:____ State:_____ Zip:_____________ Phone:____________________

How did you hear about our office? ____

PARENT OR GUARDIAN INFORMATION (MOTHER OR GUARDIAN)
Name:____ Relationship:______________________

Address: ____ Email:_____________________________

City:____ State:_____ Zip:_____________ Phone:____________________

Social Security# ______-_______-______ Birthdate: ____/_____/_______ Cell Phone:_______________________________

Employer:_________________________________Occupation:________________________Work Phone____________________

May we send you a text message confirming future appointments? _____ YES _____ NO Cell Carrier __________________

PARENT OR GUARDIAN INFORMATION (FATHER OR GUARDIAN)
Name:____ Relationship:______________________

Address:____ Email:___________________________

City:____ State:_____ Zip:_____________ Phone:____________________

Social Security# ______-_______-______ Birthdate: ____/_____/_______ Cell Phone:_______________________________

Employer:________________________________Occupation:__________________________Work Phone____________________

PRIMARY DENTAL INSURANCE
Insured's Name:____ Relationship:_____________________

Social Security# _______-________-_______ Birthdate: ____/_____/_______ Phone:________________________________

Employer:____

Insurance Company___________________________ Group#____________________ ID#_____________________________

Ins. Co. Address_____________________________________ City:______________________ State:______ Zip:_____________

____ Date_________________
Signature of Parent or Guardian

Financial/Insurance/Appointment Agreement

I authorize the office of Dr. B's Dentistry for Children to release any information, including the diagnosis and records of any treatment or examination rendered to me or my dependents during the period of such dental care, to third party payers. I authorize and request my insurance company to pay directly to Dr. B's Dentistry for Children, dental insurance benefits otherwise payable to me.

The office of Dr. B's Dentistry for Children only submits dental insurance claims, and only accepts insurance payments from dental insurance plans and companies. If you believe treatment or diagnosis should be billed to any other type of insurance, we will provide you with copies of the dental insurance forms enabling you to submit to the insurance of your choice. Payment from these claims will be sent to you. Additionally, payment for these services is to be paid at the time of service. Before submitting any insurance claim, please consult an attorney or insurance professional to avoid committing insurance fraud.

If the patient has two or more dental insurances, your account balance will be due after the primary insurance has been paid. The secondary dental insurance will reimburse the insured subscriber. I understand that I am financially responsible for all charges. According to Nevada State Law, all insurance claims are to be paid within 45 days of receipt of the insurance claim. I understand that any outstanding insurance balance that is due over 60 days will become my responsibility.

A parent or legal guardian (as determined by an Order of the Court) must accompany the patient to all appointments. Upon arrival please check in with the receptionist. A broken appointment is one that is canceled with less than 24 hours notice to the scheduled appointment time. Any appointment at which the patient, parent or legal guardian is not present, shall be considered a broken appointment. An arrival of 10 or more minutes past the beginning of the scheduled appointment time by the patient, parent, or legal guardian shall be considered a broken appointment.
I acknowledge there is a fee of $75 for each broken appointment.

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, with the exception of dental emergencies or when there is prepayment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection costs, postage, and attorney and court fees incurred in attempting to collect on this amount or any future outstanding balances.

Name of patient(s): ____

Name of Parent/Legal Guardian: ___________________________________

_________________________________ ____________________
Signature Date