

WELCOME TO SAGINAW PEDIATRIC DENTISTRY

TELL US ABOUT YOUR CHILD

Name:

SS#: ____-____-____ Gender: M / F

Birth Date: ____/____/____ Age: ____

Home Address:

Phone:

How'd you hear about us?

PRIMARY DENTAL INSURANCE

Employer:

Policy Holder:

Policy Holder's DOB: ____/____/____

SS #: ____-____-____

Relationship to patient:

Insurance Co. Name:

I.D. # _____ Group #: _____

Insurance Co. Phone #:

Insurance Co. Address:

FATHER'S INFORMATION

Name:

DOB: ____/____/____ SS #: ____-____-____

Home Address:

Home/Cell #:

Email:

MOTHER'S INFORMATION

Name:

DOB: ____/____/____ SS #: ____-____-____

Home Address:

Home/Cell #:

Email:

DENTAL HISTORY (CONFIDENTIAL)

Does your child have a history of, or is your child currently doing any of the following?		
Pacifier	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suck Thumb / Finger	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suck / Bite Lip	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bite / Chew Nails	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Grind Teeth	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Was your child		
Bottle Fed	Yes	No
Breast Fed	Yes	<input type="checkbox"/> No

MEDICAL HISTORY (CONFIDENTIAL)

Physician's Name:	Phone # :	
Date of Last Visit :		
Previous Hospitalizations / Surgeries / Serious Illness :		When?
Had a Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are immunizations up to date	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child taking any medication:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is your child Allergic to any medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has your child ever developed any condition including bleeding, drug or anesthesia reaction or rash requiring special treatment after last dental visit?	<input type="checkbox"/> Yes Explain :	<input type="checkbox"/> No

HEALTH HISTORY (CONFIDENTIAL)

Does your child have a Blood Disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Anemia	<input type="checkbox"/> Yes		Von willebrand	<input type="checkbox"/> Yes
Hemophilia	<input type="checkbox"/> Yes		Sickle Cell	<input type="checkbox"/> Yes
Excessive Bleeding	<input type="checkbox"/> Yes			

If you answered yes to any of these, please explain: _____

Does your child have a Heart Condition?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Artificial Valve	<input type="checkbox"/> Yes		High Blood Pressure	<input type="checkbox"/> Yes
Congenital Heart Defect	<input type="checkbox"/> Yes		Low Blood Pressure	<input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> Yes		Heart Attack	<input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> Yes		Pacemaker	<input type="checkbox"/> Yes
Rheumatic Fever	<input type="checkbox"/> Yes		Infective Endocarditis	<input type="checkbox"/> Yes
Angina (Chest Pain)	<input type="checkbox"/> Yes		Mitral Valve Prolapse	<input type="checkbox"/> Yes

If you answered yes to any of these, please explain: _____

Does your child have a Respiratory Diseases / Lung Disorder		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes		Persistent Cough	<input type="checkbox"/> Yes
Breathing Difficulty	<input type="checkbox"/> Yes		Shortness of Breath	<input type="checkbox"/> Yes
COPD	<input type="checkbox"/> Yes		Sleep Apnea	<input type="checkbox"/> Yes

Cont. HEALTH HISTORY (CONFIDENTIAL)

Does your child have special needs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
ADHD	<input type="checkbox"/> Yes		Wheelchair	<input type="checkbox"/> Yes
Behavior Disorder	<input type="checkbox"/> Yes		Hearing Impairment	<input type="checkbox"/> Yes
Autism	Yes		Head Injury	<input type="checkbox"/> Yes
Depression	<input type="checkbox"/> Yes		Developmental Challenges	<input type="checkbox"/> Yes
Down Syndrome	<input type="checkbox"/> Yes		Nervous Disorder	<input type="checkbox"/> Yes
Cerebral Palsy	<input type="checkbox"/> Yes		Psychological Disorders	<input type="checkbox"/> Yes
Vision Impairment	<input type="checkbox"/> Yes		Bipolar Depression	<input type="checkbox"/> Yes
Spina Bifida	<input type="checkbox"/> Yes			

Does your child have an infectious Disease?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
HIV/AIDS	<input type="checkbox"/> Yes		STD'S	<input type="checkbox"/> Yes
Hepatitis	<input type="checkbox"/> Yes		Tuberculosis	<input type="checkbox"/> Yes
Herpes	<input type="checkbox"/> Yes			

If you answered yes to any of these, please explain _____

Does your child have Stomach Problems?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Reflux	<input type="checkbox"/> Yes		Ulcers	<input type="checkbox"/> Yes

Does your child have Ear Problems?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Ear Tubes	<input type="checkbox"/> Yes		Recurrent Ear Infections	<input type="checkbox"/> Yes
Hearing Loss	<input type="checkbox"/> Yes			

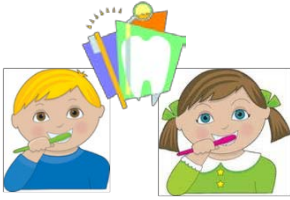
If you answered yes to any of these, please explain _____

Does your child have / had Cancer?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Chemotherapy	<input type="checkbox"/> Yes		Remission	<input type="checkbox"/> Yes, How Long
Radiation	<input type="checkbox"/> Yes		Leukemia	<input type="checkbox"/> Yes
Tumors	<input type="checkbox"/> Yes			

If you answered yes to any of these, please explain _____

Does your child have history of any of the conditions listed below?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	Yes	Liver Disease	<input type="checkbox"/> Yes
Cleft Palate	Yes	Pregnancy	<input type="checkbox"/> Yes
Diabetes	Yes	Seizures	<input type="checkbox"/> Yes
Dialysis	Yes	Sinus Problems	<input type="checkbox"/> Yes
Epilepsy	Yes	Stroke	<input type="checkbox"/> Yes
Dizziness/ Fainting	Yes	Tobacco Use	<input type="checkbox"/> Yes
Joint Replacement	Yes	Drug Use	<input type="checkbox"/> Yes
Kidney Disease	Yes	Eating Disorder	<input type="checkbox"/> Yes
Thyroid Disease	<input type="checkbox"/> Yes	Skin Rash	<input type="checkbox"/> Yes

Does your child have anything that was not mentioned?	<input type="checkbox"/> Yes	<input type="checkbox"/> N
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POLICY SHEET PATIENT INFORMATION

Last Name _____ MI _____ First Name _____

SS# _____ Date of Birth _____ Age _____

MISSED APPOINTMENT:

I understand there will be a charge of \$25 per child for missed or re-scheduled appointments without a 24 hour notice. I also acknowledge and agree that any fees incurred due to missed appointments must be paid before my child can receive further treatments/cleanings.

PAYMENT POLICY:

I understand that payment is due at the time services are rendered. Any co-payments/deductibles must be paid the day of my child's appointment. I also acknowledge and agree that payment in full is required if my insurance cannot be verified prior to my child being seen.

FLOURIDE TREATMENTS:

I have been advised that my child will receive a fluoride treatment at every cleaning appointment unless otherwise requested differently by me as the parent/guardian. I also understand that if I chose not to have fluoride on my child that it is my responsibility as the parent to let the hygienist know before cleaning begins! I also acknowledge and agree it is my responsibility to know your insurance coverage and if fluoride or other treatments given in this office are a covered benefit under my insurance plan for each visit.

NITROUS (N2O):

I understand that for the safety of my child, if he/she has eaten or drinking 1 hour before appointment, we will have to re-schedule my child's appointment for another day.

X-RAYS:

I understand that if I am coming in from another office, it is my responsibility to inform SAGINAW PEDIATRIC DENTISTRY staff of any x-rays that were taken at other dental offices. I understand that it is my responsibility to know my insurance coverage and if x-rays are a covered benefit under my insurance at time of visit(s).

I understand that any x-rays taken are the property of SAGINAW PEDIATRIC DENTISTRY and originals must be kept in THE office for 10 years. I understand and agree that

should I leave SAGINAW PEDIATRIC DENTISTRY and need copies of my child's x-rays that there will be a \$25 per child non-refundable duplication fee and that the x-rays will only be released at my request to another dental office. I also understand that the release could take up to 3 weeks to be sent to the new provider and that my child's account balance has to be zero in order for x-rays to be released.

INSURANCE:

I understand that it is a courtesy and not a requirement of SAGINAW PEDIATRIC DENTISTRY to file with my primary insurance on behalf of my child/children. I acknowledge and agree that it is ultimately my responsibility as the parent to know what my plan covers and any unpaid balances not covered by insurance is my responsibility. I understand that SAGINAW PEDIATRIC DENTISTRY will only file my primary insurance and it is my responsibility to file any secondary insurances on my own.

PARENT/GUARDIAN RESPONSIBILITY:

I understand that I as the parent am responsible for my child while under the care of SAGINAW PEDIATRIC DENTISTRY. I understand that should I allow someone other than myself to bring my child to his/her appointment that any documents signed by that person or verbal acknowledgments given by that person is ultimately my responsibility and will fall back upon me.

MEDICAL RELEASE

I give permission to my Physician or Health Provider to provide health care information regarding my child(ren)(listed above) to the dentists and staff at SAGINAW PEDIATRIC DENTISTRY.

WEB RELEASE

I give permission for the use of my child(ren)'s first name and picture: in the office, on the website and/or other advertising promotional purposes.

FOR CHILDREN 18 AND OVER (IF APPLICABLE)

I hereby authorize my child(ren) (ages 18 and above) to receive dental treatment (e.g. dental checkup, emergency visits, x-rays, cleaning, fluoride and/or treatment) without an authorized person accompanying him/her.

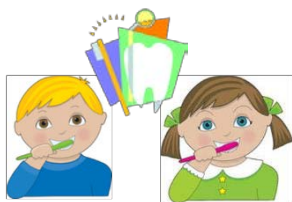
Signature of Patient, Parent, Guardian or Legal Representative

Date

Please Print Name of Patient, Parent, Guardian or Legal Representative

Relationship to Patient

_____ I, the responsible party, understand payment is due in full at time of treatment unless prior arrangements have been approved by the office manager.



PATIENT PRIVACY FORM

PATIENT INFORMATION

Last Name _____ MI _____ First Name _____
SS# _____ Date of Birth _____ Age _____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SAGINAW PEDIATRIC DENTISTRY is required by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

DISCLOSURE OF YOUR HEALTH CARE INFORMATION

TREATMENT

We may disclose your health information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

PAYMENT

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

EMERGENCIES

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

PUBLIC HEALTH

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

JUDICIAL AND ADMINISTRATIVE PROCEEDINGS

We may disclose your health information in the course of any administrative or judicial proceeding.

LAW ENFORCEMENT

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

DECEASED PERSONS

We may disclose your health information to coroners or medical examiners.

ORGAN DONATION

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

RESEARCH

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

PUBLIC SAFETY

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Parent/Guardian Signature: _____

Date _____

DENTAL HISTORY (CONFIDENTIAL)

Previous Dentist:

Address:

Date of last dental visit? _____

Were x-rays taken? Y / N

If so, what type?

DENTAL HISTORY, CONT.

Has your child had difficulty with previous dental visits? Y / N

If so, please explain:

Are you aware of any problems with your child's mouth or teeth? Y / N

If so, please explain:

Has your child ever pre-medicated for dental treatment? Y / N

If so, please explain:

DENTAL HISTORY, CONT.

Has your child injured head, mouth or teeth?

Y / N

If yes, please explain:

Is your child's water fluoridated? Y / N

Does your child take fluoride supplements? Y / N

COMMENTS/QUESTIONS/CONCERNS