University Pediatric Dentistry

Patient Information

Patient's Name _____ Name child goes by _____ Sex____
(First) (Middle) (Last)

Mailing Address_____
(Street) (City) (State) (Zip)

Date of Birth:_____ Age:_____ Weight_____

Child lives with: Both Parents _____Mother_____Father_____Other_____

Patient's Physician or Pediatrician's Name_____ Family Dentist_____

Names of Siblings:

Child's Name _____ DOB _____ Age _____
Child's Name _____ DOB _____ Age _____

How did you hear about us :_____

E-mail address: _____

Responsible Party Information

Mother

Name _____ Marital Status_____

Social Security No. _____ Birth date _____ Employer_____

Address if different from above_____

Phone: Home _____ Work _____ Cell _____

Father

Name _____ Marital Status_____

Social Security No. _____ Birth date _____ Employer_____

Address if different from above_____

Phone: Home _____ Work _____ Cell _____

Dental Insurance Information

Primary Insured's Name _____ Insured's Soc. Sec. No. _____

Insured's Birth date _____ Primary Insured's Employer_____

Insurance Co._____ Insurance Co address_____

Subscriber No._____ Group No. _____Insurance Co. Phone no._____

I hereby authorize payment of the dental benefits otherwise payable to me directly to University Pediatric Dentistry.

Signed Employee/Subscriber_____

University Pediatric Dentistry

M. Danielle Funny, DDS

Patient's Name: _____

Medical History

Has your child ever had any of the following medical problems? Please circle below

Seasonal Allergies	Y N	Seizures/Epilepsy	Y N	Thyroid Problems	Y N
Anemia	Y N	Diabetes	Y N	Mental Disorder	Y N
Asthma	Y N	Drug/Alcohol Abuse	Y N	Nervous System Disorder	Y N
Bleeding Disorder	Y N	Fainting	Y N	Rheumatic Fever	Y N
Bronchitis	Y N	Handicap/Disabilities	Y N	Speech Disorder	Y N
Cancer/Chemotherapy	Y N	Hearing Impairment	Y N	Tuberculosis	Y N
Cerebral Palsy	Y N	Hepatitis	Y N	Tumors/Growths	Y N
Congenital Heart Defect	Y N	HIV/AIDS	Y N	ADD/ADHD/ODD	Y N
Heart Murmur	Y N	OCD	Y N	Kidney Problem	Y N
Teeth Grinding	Y N	Autism/Aspergers/PDD	Y N		

If yes to any above please explain_____

Has your child experienced any other physical or mental disorder that is not listed above? Yes No
If yes, please describe: _____

Is your child allergic to any of the following drugs?
Y N Penicillin or Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes No If yes, please list_____

Is your child allergic to latex, red dye, eggs or anything else we should be aware of? Yes No
If yes, please list_____

Is your child presently under the care of a physician for any illness? Yes No
If yes, please explain_____

List <u>all</u> drugs or medicines presently being taken:_____

Has your child ever been hospitalized? Yes No
If yes, please give reasons and date(s)_____

May we request the release of your child's medical records if necessary? Yes No

Dental History

Why did you bring your child to see us today?_____

Is this your child's first visit to the dentist? Yes No

Has your child ever had a difficult experience with previous dental treatment? Yes No
If yes, please explain_____

Date of last dental visit_____ Name of Dentist_____

For what service_____

Were any x-rays taken? Yes No
If yes, have x-rays been sent to our office?_____ Date requested_____

How do you expect your child to behave in our office?_____

Do you assist child with brushing? Yes No

Does your child take any type of fluoride supplement? Yes No

Any injuries to mouth, teeth, head? Yes No Date(s) _____

If there is any information that you feel might be of value to us in the treatment of your child, please add it here:
_____

_____

I give my consent for dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name)_____.
I accept responsibility for payment of services rendered.

Signature (Parent/Guardian)_____

Today's Date _____

Reviewed by Dr. Funny / Dr. Maynor _____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to My Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to My Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
☐ **None of the above** (opt out)
□ Email
☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ___ _____

Signature of Privacy Officer