

Patient Information

Patient Name: _____ Date: _____

Last, First MI (Preferred Name)

Gender M/F Birth Date: _____ Weight: _____ How did you hear about our office? _____

Phone (Home): _____

Address: _____

Street

Apartment #

City

State

Zip Code

Health Information

Date of Last Dental Visit: 12/09/2009 Reason for this visit: _____

Have your child ever had any of the following? Please check those that apply:

AIDS

Chicken Pox

Jaundice

Sickle Cell

Allergies:

Excessive Bleeding

Kidney Disease

Speech Problems

Latex/foods/medication: _____

after bruising/extractions

Liver Disease

Tuberculosis

Anemia

Fainting

Mental Disorders

Tumors

Arthritis

Ear Infections

Measles

Thyroid Disease

Artificial Joints

Epilepsy

Mumps

Tonsillitis

Asthma

Hay Fever

Mononucleosis

Vision Problems

ADHD

Head Injuries

Nutritional Problems

Blood Transfusion

Autism

Heart Problems

Nervous Disorders

Date: _____

Bleeding Gums

Heart Murmur

Rheumatic Fever

Other _____

Bad Breath

Hepatitis

Rheumatic Heart

Behavior Concerns

High Blood Pressure

Radiation Treatment

Birth Defects

Hearing Problems

Seizures

Bladder Problems

High Fevers

Sinus Problems

Cerebral Palsy

• Does the patient have any oral habits such as thumb sucking or sleeping with a bed-time bottle? Yes No

• What is the chief concern regarding the patient's oral health? _____

• Is the child presently in good health? Yes No

• Is the child taking any medications at this time? Yes No _____

• Were there any problems with the child during pregnancy, delivery or during the child's first year of life? Yes No

*Was the child considered a "premie"? Yes No

• Has your child ever had any complications following dental treatment? Yes No

If yes, please explain: _____

• Has your child been admitted to a hospital or needed emergency care during the past two years? Yes No

If yes, please explain: _____

• Is your child now under the care of a physician? Yes No

If yes, please explain: _____

• Name of Physician: _____ Phone: _____

• Does your child have any health problems that need further clarification? Yes No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date: _____

Responsible Party Information

Name: _____

Male Female Married Single Other/Legal Guardian _____

Social Security #: _____ Birth Date: _____ DL# _____

Phone (Home): _____ (Mobile) _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

City

State

Zip Code

Insurance Information

Primary

Name of Insured: _____ SS# _____

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Insurance Phone # _____

Acknowledgement of Receipt of Notice Of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices document, our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

-I have received a copy of this office's Notice of Privacy Practices

-I have received a copy of this office's Notice of Privacy Practices, but I elect not to sign.

Please Print Name: _____

Please Sign Name: _____

Date: _____

* You May Refuse To Sign This Acknowledgement *

For Office Use Only

-We attempted to obtain oral-written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

-Individual refused to sign

-Communication barriers prohibited obtaining the acknowledgement

-Other, Please Specify _____



Consent for Pediatric Dental Treatment Of

(Children's Names)

It is necessary for us as health professionals to obtain your consent for your child's planned dental treatment or oral surgery. Please read this form carefully and ask about anything you do not understand.

1. I hereby authorize **Dr. Happy Grewal** and her assistants to perform upon my child the following dental treatment or oral surgery procedures. Including the use of any necessary or advisable local anesthesia, analgesia, conscious sedation, or x-rays.

2. In general terms the dental procedures may include:

- A. Clinical Examination
- B. Tooth cleaning and fluoride application and any necessary xrays

We do not allow insurance to dictate what is recommended for your child; therefore Dr. Grewal recommends fluoride treatment two times per year and x-rays one time per year only if last check-up was cavity free and no suspicious areas on the clinical evaluation is revealed.

- C. Applying sealants to grooves of teeth **(Guaranteed for one year from placement)**
- D. Repairing diseased or broken teeth
- E. Treating infected teeth and/or gums
- F. Removal of one or more teeth
- G. Use of Nitrous Oxide-Oxygen analgesia
- H. Use of "voice modulation" to gain attention of disruptive child
- I. Other: _____

The treatment has been explained to me, as have any alternative methods of treatment, and the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated. Therefore there can be no guarantees as to the result of treatment or as to cure. Although their occurrence is extremely remote, some risks are known to be associated with dental procedures. We're required to mention numbness, infection, and central nervous system damage. I further understand and accept that some complications could become lethal or require further medical treatment.

Signature of Parent or Guardian

Date



Financial Agreement

We expect and appreciate your full payment for all charges at the time of your visit, unless prior arrangements have been made in advance. In the event that we are seeing your child on an emergency basis and prior financial arrangements cannot be made and/or insurance eligibility can not be verified all services must be paid for in cash at the time of services.

Insurance Filing

We file all primary dental insurance claims as a courtesy for our patients. We can only make an estimate regarding your insurance benefits based upon the information provided by you and by your insurance company, thus the patient is ultimately responsible for all fees not covered by the insurance company.

Assignment of Insurance Benefits

As our office files your insurance claims, please understand the following: I/We will hereby assign directly to Growing Grins PLLC., dental insurance benefits otherwise payable to me/us for dental treatment received and/or agreed upon this date. I/We hereby authorize the release of any/all information relating to my/our insurance claims I/We understand fully that we are responsible for all charges not paid by this assignment.

Delinquent Accounts

An account is considered delinquent when payment is delayed by 30 days or more. These accounts are subject to a reasonable service charge and/or legal interest rates.

Collection Proceedings

In the event that your account becomes delinquent for non-payment or insufficient funds you will be responsible for payment of reasonable collection costs\service charges of 30% and/or attorney fees, in addition to the balance owed. Accounts turned over to collections will forfeit any past special fees and/or discounts. Such special fees and/or discounts will be reversed and you will be responsible for the full fees for procedures at the initial time of service.

Failed Appointments

We understand that regrettable circumstances often prevent making a scheduled appointment, thus we will do our best to accommodate and reschedule your appointments. Additionally, we appreciate your understanding and adherence to notifying our office **not less than 24hrs** prior to your scheduled appointment. Because missed appointments are very costly to our practice any patients failing to show for an appointment will be assessed a \$25.00 missed appointment fee, per child that is appointed.

Agreement

I/We have completely read and understand the content of this agreement and will comply with the policies within.

Responsible Party Signature

Date