CHILD PATIENT INFORMATION

Patient Name:____ Date: __________
Last First MI (Preferred Name)

☐ Male ☐ Female

Social Security #:_______________________ Birth Date:_______________________

Address: ____
Street Apartment #
____
City State Zip Cod

Parent's E-Mail Address: ______________________________________

Phone (Home):___________ (Work):___________ Ext:______ **(MOBILE):**___________

Employment Information

Employer Name:_________________________ Occupation: ____________________

Address: ____
Street City, State Zip Code Phone

Is your child covered by dental Insurance? ☐ YES ☐ NO, (If Yes, please fill out Dental Insurance Information below.)

Insurance Information

PRIMARY INSURANCE

Name of Insured Subscriber: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Subscriber ID #: ________________ Plan Group #: _________________________

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Company Name: ____

SECONDARY INSURANCE

Name of Insured Subscriber: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Subscriber ID #: ________________ Plan Group #: _________________________

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Company Name: ____

MEDICAL AND DENTAL HISTORY

Is your child in good health? ☐ YES ☐ NO

Has your child ever been hospitalized? ☐ YES ☐ NO Why? ____________________

Has your child had a medical checkup in the last year? ☐ YES ☐ NO

Is your child sensitive to any drugs or foods? ☐ YES ☐ NO

If so, what drugs or foods? ____________________

Is your child allergic to latex? ☐ YES ☐ NO

Is your child taking any medications? ☐ YES ☐ NO What? ____________________

Has your child had surgery or is any surgery contemplated? ☐ YES ☐ NO

Operation and dates: ____________________

Is this your child's first visit to a dentist? ☐ YES ☐ NO

Has your child experienced any unfavorable reaction to previous dental care? ☐ YES ☐ NO

If so, briefly describe: ____________________

Ear/Hearing Problems	☐ YES	☐ NO	Endocrine Problems	☐ YES	☐ NO
Autoimmune Problems	☐ YES	☐ NO	Skeletal/Muscle Problems	☐ YES	☐ NO
Blood Disease	☐ YES	☐ NO	Cancer/Tumors	☐ YES	☐ NO
Diabetes	☐ YES	☐ NO	Eye/Vision Problems	☐ YES	☐ NO
Cardiovascular/Heart Problems	☐ YES	☐ NO	Kidney Problems	☐ YES	☐ NO
Liver Problems	☐ YES	☐ NO	Neurological Problems/Seizures	☐ YES	☐ NO
Asthma/Breathing Problems	☐ YES	☐ NO	GI/Stomach/Digestive Problems	☐ YES	☐ NO
Genetic Problems	☐ YES	☐ NO	MRSA Positive	☐ YES	☐ NO
Developmental Delay	☐ YES	☐ NO	Autism/ADHD	☐ YES	☐ NO
G-Tube Placement	☐ YES	☐ NO	To Much Saliva/Drooling	☐ YES	☐ NO
Teeth Grinding	☐ YES	☐ NO	Cleft Lip/Palate	☐ YES	☐ NO

Any other Special Needs and please describe anything from above:

Please describe your child's diet: (Organic, Gluten Free, juice, sodas, fruits, and vegetables?

Does your child take liquids at bedtime or at night in a bottle or sippy cup? ☐ YES ☐ NO

Does your child drink Pediasure or similar? ☐ YES ☐ NO

Are you currently breast feeding your child? ☐ YES ☐ NO

Does your child use a pacifier? ☐ YES ☐ NO

Has or does your child suck a thumb or finger(s)? ☐ YES ☐ NO

Are you opposed to fluoride treatments for your child? ☐ YES ☐ NO

Are you opposed to mercury containing silver fillings for your child? ☐ YES ☐ NO

AUTHORIZATION FOR TREATMENT

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my child's health or medication.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of my dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon my child and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents embodies some risks. I understand that I can ask for a complete recital of any possible complications.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice and for the payment to be applied directly to any outstanding balance on my account.

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 options, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available in our office and on our website, and 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 have the right to revoke this consent at any given time by giving us written notice of your revocation submitted to Dr. Halloran. Please understand that 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 you or to continue treating you if you revoke this Consent

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

A service charge of 1% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination and treatment plan.

Signature of parent: ____ Date: ___________________________________

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

Personal Representative's Name: ____

Relationship to Patient: ____

Dentist Signature ____ Date _________________________