Welcome to our Practice!

CHILDREN & TEEN DENTAL
orthodontics & pediatric dentistry

PATIENT INFORMATION

Today's Date: _____ Patient's Dentist: _____

Patient's Full Name: _____ Name child goes by: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Email Address: _____

Patient's Date of Birth: _____ Age: ___ Sex: ___M ___F SSN: ___-___-___

School: _____ Grade: _____

Name and ages of other children in family: _____

What is the reason for your child's visit? (Please circle)

Yes No Dental Consultation/Visit (If Yes, please complete Pediatric Dental Addendum attached)

Yes No Orthodontic Treatment

If patient is a minor, parent or guardian name: _____

Who has legal custody of Patient: _____ Insurance Policy Holder: ___Yes ___No

Whom may we thank for referring you to our office? _____

How did you hear about us? _____

RESPONSIBLE PARTY INFORMATION

Full Name: _____ Marital Status: _____

Address: _____
Street City State Zip

How long at this address: ___ Home Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone Carrier: _____ Email: _____

Social Security Number: ___-___-___ Date of Birth: _____

Relationship to patient: _____ Employer: _____ #Yrs. _____

PRIMARY INSURANCE INFORMATION

Insured's Full Name: _____ Insured's SSN: ___-___-___

Insurance Co. _____ Group/Policy # _____ Phone: _____

Insurance Co Address: _____ Insured's Birth Date: _____

Insured's Employer: _____ Insured's Employer Phone: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insured's Name (Full Name): _____ Insured's SSN: ___-___-___

Insurance Co. _____ Group/Policy # _____ Phone: _____

Insurance Co Address: _____ -_____

Insured's Employer: _____ Insured's Employer Phone: _____

EMERGENCY INFORMATION

Name of Emergency Contact person: _____ Phone: _____

Address: _____

Parent's Signature (if a minor): _____

Patient's Last & First Name: _____, _____ Date of Birth: _____

MEDICAL HISTORY

Physician: _____ Date of last visit: _____ Phone: _____
Name of Practice: _____ Address: _____

PLEASE CIRCLE Yes or No (If Yes, please fill in details.)

Yes No Is your child in good health? Date of last Physical Exam: _____
Yes No Has your child ever had a health problem? _____
Yes No Has your child ever been hospitalize or had any major operations? If Yes, please give reason and date/s: _____
Yes No Were there any problems at birth? If Yes, please explain: _____
Yes No Is your child taking any medications? Please give medication name, dose and reason: _____
Yes No Is your child allergic to any medications? _____
Yes No Does your child have a history of a major illness? _____
Yes No Has your child had any major operations? _____
Yes No Has your child ever been involved in a serious accident? _____

PLEASE MARK if your child has or has been treated for any of the medical conditions/health issues and elaborate below:

__Abnormal Bleeding	__Dizziness	__Mental Delays
__ADD/ADHD	__Endocrine/Growth	__Neuromuscular Disorder
__Adverse Drug Reactions	__Epilepsy	__Nervous Problems
__Anemia	__Eyesight	__Personality/Social
__Arthritis	__Frequent Infections	__Physical Delays
__Asthma/Hay Fever	__GI Disorders	__Pneumonia
__Autism	__Heart Problems	__Recurrent Headaches
__Bleeding/Transfusions	__Hepatitis	__Rheumatic Fever
__Blood Disorder	__Heart Disease	__Prolonged Bleeding
__Bone Disorders	__Heart Murmur	__Radiation/Chemotherapy
__Cancer/Tumor	__HIV/Aids	__Seizures
__Cerebral Palsy	__High Blood Pressure	__Sickle Cell Disease/Trait
__Cleft lip/palate	__Kidney Problems/Disease	__Significant Injuries
__Congenital Heart Defect	__Herpes	__Speech/Hearing
__Diabetes	__Liver Problems	

Details on any checked item: _____

Are there any other medical conditions not listed that we should be aware of? _____

Patient's Last & First Name: _____, _____ Date of Birth: _____

DENTAL HISTORY

Dentist: _____ Date of last visit: _____
Phone: _____ Address: _____

PEDIATRIC DENTAL HISTORY—

PLEASE CIRCLE Yes or No (If Yes, please fill in details.)

Yes No Has your child ever been to the dentist?
Date of last x-rays (if taken): _____
Name of Dentist: _____ Date: _____
Yes No Has your child experienced any unfavorable reaction from previous dental care?
Yes No Does your child suck a finger, thumb, or pacifier?
Yes No Does your child have pain with chewing, yawning, or wide opening of his/her mouth?
Yes No Does your child's jaw make noise and is pain associated with the sounds?

What concerns you most about your teeth? _____
Yes No Are you presently experiencing any dental pain? Explain: _____
_____
Yes No Have you ever lost or chipped any teeth? _____
Yes No Have there been any injuries to your mouth or teeth face? _____
Yes No Is any part of your mouth sensitive to temperature or pressure? _____
Yes No Do your gums bleed when your brush? _____
Yes No Do you have any type of thumb or tongue habit? _____
Yes No Are you a mouth breather? _____
Yes No Have you ever seen an orthodontist? _____
Yes No Has anyone in the family received orthodontic treatment? _____
How did they feel about their result? _____
What is your attitude towards receiving orthodontic treatment? _____

AUTHORIZATION & RELEASE

- I have read and answered the above questions to the best of my knowledge.
- I authorize my insurance company to pay Children & Teen Dental Group all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize Children & Teen Dental Group to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of Patient or Responsible Party: _____ Date: _____

PARENTAL PERMISSION TO CONSENT

Please provide the names of any persons whom you consent to bring your child to dental appointments. Keep in mind that this person will be able to consent for treatment and will be financially responsible for any payments on that day of service.

_____ _____
_____ _____

Signature of Patient or Responsible Party: _____ Date: _____

Pediatric Dental Addendum to New Patient Application

ACKNOWLEDGEMENT OF RECEIPT--Notice of Privacy Practices
(Health Insurance Portability & Accountability Act-HIPAA Acknowledgement)

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this Authorization receives a written revocation, although this revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

You may refuse to sign this acknowledgement.
I, _____, have read on line at the childrenandteendentalgroup.com website and/or received a copy of Children & Teen Dental Group's *Notice of Privacy Practices*.
Please print name: _____ Signature: _____
Date: _____

FINANCIAL RESPONSIBILITY
I understand that the treatment plan is our best estimate of insurance coverage. However, after insurance processing, I understand and agree that I am responsible for the remaining balance and will be billed accordingly. Under most insurance plans, Nitrous Oxide is not a covered benefit. In the event you elect to use Nitrous Oxide and it is not a covered benefit, we will collect the $68.00 at the time of service and will not bill your insurance. I hereby authorize any payment of dental benefits to be made directly to Children & Teen Dental Group. I also understand that any amount not covered by my insurance policy is my responsibility and is due at the time of treatment. I authorize treatment to be rendered and assume financial responsibility. I acknowledge that all non-current balances and accounts over 60 days will be charged a service charge of 1.5% per month (18% per year) on the unpaid balance. The cost incurred in collecting this account including court costs, agency fees and attorney fees will be added to the balance due.

Signature of Patient or Responsible Party: _____ Date: _____

CONSENT FOR DENTAL TREATMENT
I request and authorize Children & Teen Dental Group to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Children & Teen Dental Group to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Children & Teen Dental Group will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

Signature of Patient or Responsible Party: _____ Date: _____

PHOTO & VIDEO RELEASE
I hereby give permission for images of my child captured during any/all Children & Teen Dental Group visits or activities of events through video, photo and digital camera, to be used solely for the purposes of Children & Teen Dental Group; promotional material and publications and waive any rights of compensation or ownership thereto.

Signature of Patient or Responsible Party: _____ Date: _____