Patient ID# ______

Today's Date ______

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name ______

Nickname ______ Sex ______

Birthdate ______ Age ______

SS#/SIN ______

School ______ Grade ______

Child's Home Address ______

______

City ______

State/Prov. ______ Zip/P.C. ______

Phone ______

______

Responsible Party

Name ______

Relationship ______

Address ______

______

SS#/SIN ______

DL # ______

Email ______

☐ Mother

☐ Stepmother ☐ Guardian

Name ______

Home Phone ______

Work Phone ______

Cell Phone ______

SS#/SIN ______

Employer ______

______

Occupation ______

______

DL # ______

______

☐ Father

☐ Stepfather ☐ Guardian

Name ______

Home Phone ______

Work Phone ______

Cell Phone ______

SS#/SIN ______

Employer ______

______

Occupation ______

______

DL # ______

______

Primary Dental Insurance

Insured's Name ______

Relationship ______

Birthdate ______ SS#/SIN ______

Employer ______ Date Emp. ______

Occupation ______

Ins. Company ______ Group # ______ Emp. # ______

Ins. Company Address ______

Deductible ______ Amount already used ______ Max. annual benefit ______

Orthodontic coverage ☐ Yes ☐ No

Additional Insurance

Insured's Name ______ Relationship ______

Birthdate ______ SS#/SIN ______ Employer ______

Date Emp. ______ Occupation ______

Ins. Company ______ Group # ______ Emp. # ______

Ins. Company Address ______

Deductible ______ Amount already used ______

Max. annual benefit ______

Orthodontic coverage ☐ Yes ☐ No

Parent's Marital Status

☐ Single ☐ Divorced

☐ Married ☐ Widowed

☐ Separated

Who is responsible for making appointments?

Name ______

Home Phone ______

Work Phone ______ Ext. ______

Cell Phone ______

Best time to call (Time) ______ (Days) ______

Over Please

Health History

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had difficulty with previous visits? ____________

Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ____________

Has your child ever taken Fen-Phen/Redux? ____________

Has your child ever had any of the following:

- Asthma ☐ YES ☐ NO
- Cancer ☐ YES ☐ NO
- Hepatitis ☐ YES ☐ NO
- HIV/AIDS ☐ YES ☐ NO
- Hemophilia ☐ YES ☐ NO
- Diabetes ☐ YES ☐ NO
- Allergies ☐ YES ☐ NO
- Rheumatic Fever ☐ YES ☐ NO
- Congenital Heart Defect ☐ YES ☐ NO
- Handicaps/Disabilities ☐ YES ☐ NO
- Convulsions/Epilepsy ☐ YES ☐ NO
- Tuberculosis ☐ YES ☐ NO
- Abnormal Bleeding ☐ YES ☐ NO
- Heart Murmur ☐ YES ☐ NO

Please explain any medical problems that your child has

____

Child's Habits

How often does your child brush? ____________

How often does your child floss? ____________

Date of last dental visit ____________

Previous Dentist ____________

Child's Physician ____________

Phone Number ____________

Child's Birthdate ____________

Is your child's water fluoridated? .... ☐ YES ☐ NO

Does your child take fluoride supplements? ☐ YES ☐ NO

Does your child:

- Suck thumb/finger .... ☐ YES ☐ NO
- Suck/Bite lips .... ☐ YES ☐ NO
- Bite/Chew nails .... ☐ YES ☐ NO
- Chew hard objects (Pencils, etc.)..... ☐ YES ☐ NO
- Grind Teeth ☐ YES ☐ NO
- Clench jaws .... ☐ YES ☐ NO

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ____________

Signature of patient or parent/guardian if minor

____

Date

Dentist's Review

____

Date ____________

Signed Dr. ____________

Health History Update

Date ____________

Comments ____________

Signature ____________

Date ____________ Comments ____________

Signature ____________

16307/051-1196

AUTHORIZATION AND RELEASE

I authorize the **Brookwood Dental/dentist** to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

HIPAA POLICY

I understand that under Health Insurance Portability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up amoung the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality physicians.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Financial Policy & Agreement

BROOKWOOD DENTAL CENTER financial policy is outlined below:

1. **Payment is due at the time the service is rendered** unless financial arrangements have been made with the office manager. We accept cash, checks, Visa, MasterCard, American Express, and Discover. Care Credit is offered as an option for extended payment. Our office manager will help to explain this method of financing.
2. **Insurance** - Insurance should be viewed as an aid in helping make dental treatment affordable. The dentist may provide several treatment options and we encourage our patients to decide which is best, rather than their insurance directing their dental care. Dental insurance will generally not pay for 100% of services and the patient will have a deductible and/or co-payment that they are responsible for paying.
   a. Please provide **your insurance card**. This will help estimate your insurance benefits.
   b. **Co-payments and deductibles are due on the date of service**.
      - The patient is responsible for any balance that the insurance does not cover. Pretreatment Estimates by the insurance company are not guarantees of payment and the patient is responsible for unpaid balances.
      - We will file your insurance **as a courtesy** and follow-up on delayed claims for 90 days. After this time **any unpaid balance is the responsibility of the patient**. Insurance is a contract between the employer, the insurance company, and the patient. Problems that extend beyond 60 days should be taken up with your human resources director at your place of employment.
3. We employ a **24 hour cancellation policy**. We reserve the right to charge a fee for broken appointments.

I hereby agree that all dental bills are due and payable upon receipt. Should my account become delinquent and require the services of an attorney for collection, I agree to pay any fees associated with collecting the debt, including collection agency fees and court costs..

All accounts must be paid in full within 90 days of statement billing to avoid collection procedures.

I HAVE READ, UNDERSTAND, AND AGREE TO THE INFORMATION ABOVE.

Patient Name:______________________________________Date: __________________

Signature of Patient or Guardian:____