Welcome

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

1 Tell Us about Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____)_____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

2 General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date: _____

Dentist's Phone #: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____

_____
City State Zip

3 Parent's Information

Person Responsible for Account: _____ Parent's Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced

☐ **Mother** ☐ **Father** ☐ **Step Parent** ☐ **Guardian**

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____)_____

_____

_____

SS #: _____ DL #: _____

Wk #: (____)_____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

☐ **Mother** ☐ **Father** ☐ **Step Parent** ☐ **Guardian**

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____)_____

_____

_____

SS #: _____ DL #: _____

Wk #: (____)_____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

4 Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits other wise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Guardian Date

Continued on Back

5 Dental History

Why did you bring the child to the dentist today? _____

_____

_____

Has the child ever taken Fosamax or any other bisphosphonate? If so, when? _____ ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: _____

_____

Aside from items listed, please list all drugs/things that the child is allergic to:

_____

_____

☐ Yes ☐ No Latex ☐ Yes ☐ No Metals/Nickel ☐ Yes ☐ No Plastic

6 Medical History

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Hearing Impairment
Y	N	ADD/ADHD	Y	N	Heart Murmur
Y	N	AIDS/HIV+	Y	N	Hepatitis
Y	N	Anemia	Y	N	High Blood Pressure
Y	N	Any Hospital Stays/Operations?	Y	N	Hives
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asperger Syndrome	Y	N	Liver Problems
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Autism	Y	N	Lupus
Y	N	Cancer	Y	N	Measles
Y	N	Chicken Pox	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Mononucleosis
Y	N	Convulsions	Y	N	Prosthetics
Y	N	Diabetes	Y	N	Rheumatic Fever
Y	N	Epilepsy	Y	N	Scarlet Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Skin Rash
Y	N	Handicaps/Disabilities	Y	N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed:

_____

_____

Does/did the child experience any of the following?

Y	N	Breast Fed	Y	N	Nursing Bottle Habits
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue/Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. _____

Signature of Dentist Date

Dentist's Comments: _____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N

If Yes, please explain. _____

_____

_____

Parent/Guardian Signature Date

_____

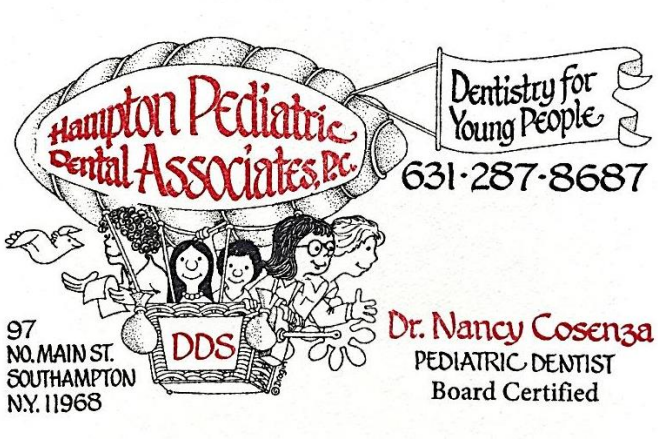
Dentist Signature Date

_____

Parent/Guardian Signature Date

_____

Dentist Signature Date



HIPPA - PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient Name:_____

Relationship to Patient:_____

Signature: _____

Patient Missed Appointment Policy

In an effort to improve access for all patients, Hampton Pediatric Dental will actively work to reduce missed appointment activity, or no show appointments. We aim to provide the best quality of care for your child's dental needs.

To ensure our patients do not miss their appointments, Hampton Pediatric Dental uses an automated appointment reminder system that sends out alerts through phone call, email, and text messaging.

Please make sure that all of your contact information is up-to-date each time you check in for an appointment.

We understand that circumstances arise resulting in the need to cancel an appointment.

Please notify us of any cancellations **24 hours prior** to your scheduled appointment time. This will allow our office enough time to fill the appointment slot with another patient in need.

Hampton Pediatric Dental also understands that emergencies and unforeseen circumstances may cause our patients to miss an appointment. For this reason, after your first missed appointment we will give you an opportunity to reschedule.

However, if two missed appointments occur, you will be charged a $25 fee.

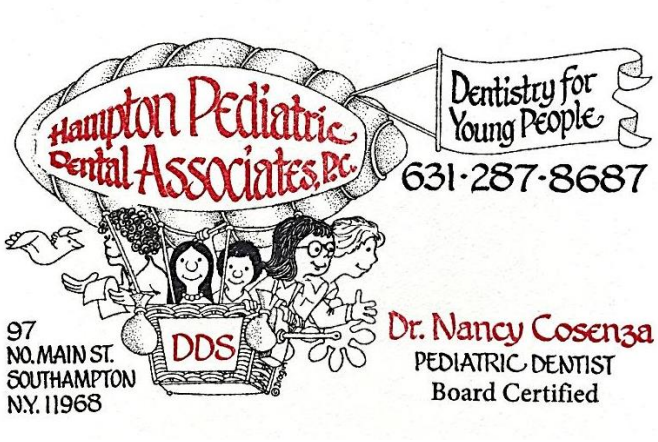
We hope we can work with you to prevent this from happening.

_____ _____

Patient Name (Printed) Date of Birth

_____ _____

Patient/Guardian Signature Date



PAYMENT AGREEMENT

By signing this form I understand that Hampton Pediatric Dental Associates will bill my child's insurance first for my child's treatment today. If for any reason the insurance company does not pay any or part of the bill I will be responsible for payment. If the patient does not have any insurance, I am aware that payment is due at the time of the visit.

Date: _____

Print Patient Name:_____

Relationship to Patient:_____

Signature: _____