



To help us better serve you, please complete the following forms to the best of your ability.
If you have questions, do not hesitate to let us know. Thank you for choosing our office!

Child's Name: _____ DOB (MM/DD/YY): _____

Nickname: _____ Age: _____ Social Security #: _____

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Declined Gender: Male Female Other

Race: White Black/African American American Indian Asian Native Hawaiian Pacific Islander
 Other Declined

Home Address: _____

City, State, Zip: _____ Phone Number: _____

Who can we thank for referring you to us? (Please check all that apply.)

Primary Care Doctor

Friend/Family

General Dentist

School/Daycare

How have you heard about us? (Please check all that apply.)

Social Media

Newspaper or magazine feature/ad

Google/Website

School/Daycare

Insurance Directory

Community Event/Festival

Drive-by/Signage

Commercial or video

Billboard

Other _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Mother/Guardian)

Name: _____ Relationship: _____

DOB: _____ Social Security #: _____ Email Address: _____

Home Address (if different than child): _____

City, State, Zip: _____ Phone Number: _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Father/Guardian)

Name: _____ Relationship: _____

DOB: _____ Social Security #: _____ Email Address: _____

Home Address (if different than child): _____

City, State, Zip: _____ Phone Number: _____

PRIMARY DENTAL INSURANCE:

Insurance Company: _____ Insured's Name: _____
Relationship to Patient: _____ DOB: _____ Social Security #: _____
Employer: _____ Subscriber's ID: _____ Group #: _____

SECONDARY DENTAL INSURANCE:

Insurance Company: _____ Insured's Name: _____
Relationship to Patient: _____ DOB: _____ Social Security #: _____
Employer: _____ Subscriber's ID: _____ Group #: _____

FLUORIDE CONSENT

Most insurance companies cover fluoride treatment twice a year; however, some insurance companies only pay for a once-a-year application.

PLEASE CHOOSE ONE (1) OF THE FOLLOWING:

- I, _____ give my consent to apply fluoride treatment TWICE a year. I agree that if my insurance company does not pay for the second application, that I am financially responsible for payment.
- I, _____ give my consent to apply fluoride treatment only ONCE a year.
- I, _____ do not wish fluoride treatment to be applied to my child at any time.

FINANCIAL ARRANGEMENTS/INSURANCE AGREEMENT

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

Any unpaid balance due (as listed on a billing statement), not paid within 28 days of the monthly billing date, will be assessed a late charge of 1.5% each month. I realize that failure to keep this account current may result in my children being unable to receive additional dental services except for dental emergencies or when there is pre-payment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection cost (33% of the unpaid balance), postage, attorney and court fees incurred in attempting to collect on this amount or any future outstanding balances.

I hereby authorize the office to contact the designated phone numbers and/or email address listed in the patient's account. With this authorization, a message/communication may be left indicating appointment time and dates, reminders, balances due, and/or estimated co-pays for future visits.

Financially responsible person for account Self Other _____

Signature of Parent or Legal Guardian Date

Child in foster care- Children & Youth and Foster Parents will not sign Staff Initials _____

HEALTH/DENTAL HISTORY

Patient Name: _____ Male Female Date of Birth: _____

Best Contact Number: _____ Best Day to Contact and Time: _____

Parent/Legal Guardian: _____ Documentation of Court Order on file

Foster Parent: _____ Case worker: _____ Phone Number: _____

Primary Care Physician Name: _____ Phone Number: _____

Specialists: Name of Facility/Doctor: _____ Phone Number: _____

Name of Facility/Doctor: _____ Phone Number: _____

Reason seen by Specialist: _____ Date last seen: _____

ALLERGIES: No Known Allergies Medications Food Seasonal/Environmental Tape Latex

Allergy	Reaction

MOTHER/FATHER ALLERGIES: No Known Allergies Allergy and reaction: _____

PATIENT MEDICATIONS: None taken Takes Medications (please list below.)

Medication	Dosage	Frequency	Reason

SURGERIES/HOSPITALIZATIONS: No surgery/hospitalization Admitted to hospital or had surgery (please describe below.)

Date	Surgery/Hospitalization	Outcome

Anesthesia Problems: No Known Anesthesia Problems

Has the child or anyone in the family been diagnosed with the following:

Malignant Hyperthermia Pseudocholinesterase Disease Severe Postop Nausea/Vomiting

Airway complications: Tracheomalacia/Laryngomalacia

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Hematological System: No Known Problem with Blood Diseases

Blood diseases _____ Anemia TYPE? _____ G6PD

Bleeding tendencies/Factor deficiencies; WHICH FACTOR? _____ History of Transfusions HIV/AIDS

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Respiratory System: No Known Problems with Lungs

Asthma Emphysema Bronchitis TB Sleep Apnea

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Cardiovascular System: No Known Problems with Heart

High blood pressure Problem with heart rhythm Pacemaker Defibrillator Stroke

Mitral Valve Prolapse Murmur Phlebitis Problem with heart valves Congenital heart defect now or at birth

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Nervous System: No Known Issues

Seizures Tremors Vertigo Cerebral Palsy

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Endocrine System: No Known Issues

Diabetes Noninsulin Dependent Insulin Dependent Thyroid Disease

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Digestive System: No Known Issues

Hiatal Hernia Acid Reflux Ulcers Hepatitis Chronic constipation Chronic Diarrhea No bowel control

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Genitourinary System: No Known Issues

Kidney problems Bladder Issues Bed

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Reproductive System: No Known Issues

Last Menstrual Period _____ ; or Not Applicable Ovarian Cysts Endometriosis

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Skeletal System: No Known Issues

Arthritis Neck/Back Problems Mobility Limitations Wheelchair-bound Assistive device: _____

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Psychosocial: No Known Issues

Mental health disorder Sleep disorder Recent life changes/stressors

Late sleeper Heavy sleeper ADD ADHD Autism

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Skin: No Known Issues

Psoriasis Eczema Bruises Easily

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Infection: No Known Issues

MRSA VRE CDIFF When? _____ Where? _____ Last test performed? _____

**** Office Use ONLY:** Request for negative culture faxed to PCP Negative culture received and on file

Other: No Known Issues

Cancer Microencephalopathy Down's Syndrome Dwarfism Recent illness Congenital Anomaly

Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** _____

Does patient have: Glasses Hearing Aids – L / R Loose/Capped/Missing Teeth – Upper / Lower N/A

Exposure to second hand smoke yes no Illicit drug use in the family yes no

Alcohol abuse in the family yes no History of physical abuse in the family yes no

Visited a hurricane-affected area yes no

The above information is accurate to the best of my knowledge.

Parent Signature: _____ Date: _____

USE AND DISCLOSURE OF HEALTH/DENTAL INFORMATION

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protection health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: 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 operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this consent. 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 may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact: Practice Manager - Brook Murphy
Telephone: 484-787-2900 **Fax:** 484-698-7848
Email: BMurphy@ChildrensDentalHealth.com
Address: 200 Willowbrook Lane, Suite 220, West Chester, PA 19382

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand the 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 your child if you revoke this consent. I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations

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

Patient's Name: _____

Relationship to Patient: _____

Personal Representative's Name: _____

Signature

Date

**Thank you for completing this questionnaire.
We look forward to caring for your child.**

YOU ARE ENTITLED TO A COPY OF YOUR PAPERWORK AFTER SIGNED.