

Health History Form

Today's Date: _____

Tell Us About Your Child

Child's Name _____

Nickname _____ Male Female

Siblings _____

Child's Birthdate ___/___/___ Child's Age _____

School _____ Grade _____

Hobbies _____ Pets _____

Home Address _____

City _____ State _____ Zip Code _____

Mother's Information

Name _____

Mother Stepmother Guardian Birthdate ___/___/___

Employer _____

Cell # () _____

Home # () _____

Work # () _____

SS # _____ DL# _____

Email Address _____

Father's Information

Name _____

Father Stepfather Guardian Birthdate ___/___/___

Employer _____

Cell # () _____

Home # () _____

Work # () _____

SS # _____ DL# _____

Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

Cell # () _____

Home # () _____

Email _____

Dental Insurance

Insurance Co. Name _____

Insurance Co. Phone # () _____

Group # _____ ID # _____

Policy Holder's Name _____

Relationship to Patient _____

Policy Holder's Birthdate ___/___/___

Social Security # _____

Policy Holder's Employer _____

Who May we thank for referring you to our office?

Doctor Friend Internet Other Website

Name of Dr, Friend or Patient who referred you

Dental History

Is this your child's first dental visit? _____

If not, when was last visit? _____

Previous Dentist's name: _____

Office phone Number _____

Were any x-rays taken at previous office? Y N

If yes, date of x-rays _____

Have there been any injuries to the teeth, face or mouth? If yes, please explain _____

Please check the reason for seeking dental care:

◇ Complete Checkup ◇ Toothache ◇ Accident

◇ Appearance of teeth

◇ Other _____

Does the child have any of the following habits?

◇ Thumb Sucking ◇ Nail Biting ◇ Pacifier

◇ Mouth Breathing ◇ Sippy Cup ◇ Tongue Thrust

◇ Lip Sucking ◇ Nursing/ Bottle habit

◇ Other _____

Has the child ever had a serious problem associated with previous dental work? Y N

If yes, please explain _____

Has your child had an unfavorable experience in a dental or medical office? Y N

If yes, please explain _____

Any unusual speech habits? _____

Does your child have problems in: ◇ Learning

◇ Concentration ◇ Cooperation ◇ Understanding

How do you think the child will react to dental treatment?

◇ Excellent ◇ Good ◇ Fair ◇ Poor

Is there any special information that you believe would be helpful to us in your child's visit today or in general? _____

Is your child currently taking Fluoride?

◇ Yes ◇ No

If yes, How?

◇ Fluoride Pill ◇ Vitamins with Fluoride

◇ School Rinse ◇ Fluoridated Bottled Water

◇ Mouthwash ◇ Fluoride Gel

◇ Other _____

Medical History

Name of Child's Pediatrician _____ Phone _____

Date of Last Examination _____ Are all Vaccinations up to date? Y N If No, why _____

Is the patient currently taking any medication? Y N

◇ Antibiotics ◇ Anticoagulants ◇ Tranquilizers ◇ Anticonvulsants ◇ Other _____

List Current medications, dosages and reasons for taking them _____

Does the patient have a history of allergies? Y N If yes, please check all that apply: ◇ Penicillin ◇ Aspirin
◇ Antibiotic other than Penicillin ◇ Anesthesia ◇ Latex ◇ Food ◇ Other _____

Describe symptoms of reaction: _____

**If the Patient has a history of the following,
Check all that apply:**

- | | |
|--|--|
| <input type="checkbox"/> Hearing Difficulties | <input type="checkbox"/> ADHD/ADD |
| <input type="checkbox"/> Speech Difficulties | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Emotional Difficulties | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Eye Problems | <input type="checkbox"/> Muscle Weakness |
| <input type="checkbox"/> Liver problems or Hepatitis | <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Disease(s) Affecting normal Growth |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bone or Joint Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Skin Problems | <input type="checkbox"/> HIV +/-Aids |
| <input type="checkbox"/> Heart Problems/Murmur | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Any Reason for child to premedicate before a dental visit? Y N If yes, Reason _____ |

Dr's Comments _____

Has Your Child ever been hospitalized? Y N If yes, please explain _____

Please describe any medical treatments including drugs, pending surgery, recent injuries or any information that you would like to make us aware of that has not been covered by the medical or dental history _____

Is there anything you would like to discuss with the doctor in private or without your child present? Y N

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is **my** responsibility to inform this office of any changes in my child's medical status as well as any changes to my Insurance information, phone number and address. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date

Relationship to Patient

Thank you for choosing us as your dental care provider. We are committed to providing you with the best quality of care and service. The following is a statement of our Financial Policy, which we require that you sign prior to any treatment. All patients must complete our Information form completely before seeing the doctor. **ALL PAYMENTS AND CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE BY WHO EVER BRINGS THE CHILD TO THE APPOINTMENT.** However, the amount that you are asked to pay at the time of service is only an **ESTIMATE** of what the insurance is not going to cover. You will be billed for the difference when our office receives the insurance payment.

Should your account become a collection problem with our office, all future appointments will need to be paid in full at the time services are rendered whether you have dental insurance or not.

Insurance

Regarding insurance plans, we are participating providers with **Cigna, Guardian, Aetna and Delta Dental** insurance companies. However, if your policy allows you to see any dentist of your choice, as a courtesy to you, we will file your insurance claim on your behalf with the information you provide to us. Co-payments and deductibles are due at the time of service. Co-payments include the portion of the bill, which the insurance company indicates as the patient's responsibility.

Insurance- Non-Participating Provider or No Insurance

In the event that your insurance coverage changes to/or is a plan where we are not participating providers or if you do not have insurance coverage, we do require 100% of the bill to be paid at time of service **BY WHOEVER BRINGS THE CHILD TO THE APPOINTMENT.** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under certain dental plans. In the event that we must turn your account over to our collection agency for payment, you will be responsible for the fees associated with this collection process.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for dental services in our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates.

Missed Appointments

Please help us serve you better by keeping scheduled appointments. Due to an unusual amount of broken appointments, we do now reserve the right to charge for appointments broken without 24 hours advance notice and in certain cases will be forced to dismiss the patient from our practice.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to the Financial Policy.

I understand that it is my responsibility to inform the front office if there is ever a change to my personal information including any insurance changes. I will be responsible for this account regardless of what the insurance company covers.

Signature of Responsible Party

Date



If you will be using dental insurance, you must sign on both lines below



I agree to be responsible for all charges for dental services not Paid by my dental benefit plan, unless prohibited by law. To the Extent permitted by law, I consent to your use and disclosure Of my protected health information to carry out payment activities In connection with this claim.

I hereby authorize payment of the dental benefits otherwise payable to me, directly to the dentist.

Signed (patient or responsible party)

date

Signed (insured person)

date

As a courtesy to our patients, we file your insurance claim- however...

At the time of your first visit, we call and verify you insurance benefits. The insurance company gives us a general breakdown of benefits **and always tells us this not a guarantee.**

We use this general breakdown when asking you for your copay at each visit. **Please understand** that we are in no way promising you that this is all you will need to pay.

1. If the insurance company pays less than we expected, you will be responsible for the balance.
2. Each insurance company has a different list of non-covered procedures. For example, some will not cover sealants and others think this is so important they pay this procedure at 100%. If the procedure is not covered by your insurance; you will be responsible for the balance.
1. The frequency of cleaning/x-rays and other procedures that the insurance may cover are different from one company to another. If the insurance company does not pay for a visit due to frequency or for any other reason, you will be responsible for the balance.
2. If you exceed your yearly maximum, you will be responsible for the balance.
3. If the insurance company does not pay us within 45 days of our filing the claim, you will be responsible for the balance.

Please sign the following:

I understand that the amount I will be asked to pay, my copay, is based on a general breakdown of benefits and that I will be responsible for paying any amount my insurance company does not pay. I have reviewed my insurance information and verified that the names, social security numbers, addresses and birthdays are correct.

Signature of Parent or Legal Guardian

Date

PRIVACY PROTECTION AGREEMENT

In connection with the dental services that I am receiving from Dr. Mark Mays and their dental staff, I hereby authorize the doctor and their respective agents to disclose any information concerning my dental condition and treatment. Including copies of applicable medical/dental records, to:

- A. Any third party payer covering the dental services of the patient.
- B. Other health care professionals and institutions involved in the delivery of dental care to the patient.
- C. Employees, and agents of the practice, to the degree necessary to facilitate the provision of dental care services and payment for such services.
- D. Pharmacies; and
- E. As otherwise required by law.
- F.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to Dr. Mark Mays Privacy Notice.

I also hereby authorize the disclosure of personal dental information and confirmation calls to my answering machine.

This consent is valid from the date executed until revoked in writing by the patient.

Signed (Guardian): _____

Print (Guardian): _____

Date: _____