Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ❑ F ❑	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

Hollymead Dental Arts

Insurance Information:

Policy Holder: _____

Patient Relation:_____

Policy Holder's DOB: _____

Policy Holder's SS#: _____

Policy Holder's
Employer_____

Insurance
Company_____

Insurance Address_____

Insurance Phone Number_____

Group # _____

Policy (ID) #_____

How did you hear about us?

*Dentist_____

*Advertisement_____

*Insurance Carrier_____

*Family/Friend_____

*Other_____

Financial Agreement
For the office of
Hollymead Dental Arts

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care, using only the highest quality materials and technology available in the market today. We are also committed to providing you with up to date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative cost.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 30 days from the date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all of your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the assignment of benefits agreement. In order for your practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Your estimated copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of the insurance payments. Our practice accepts cash, money orders, personal checks, Visa, MasterCard, Discover, American Express and Flex spending cards for payment. Third party, extended payment financing is available upon request and approval with CareCredit.

Returned checks and balances older than 31 days will be subject to collection fees, finance charges at the rate of 1.5% per month (18% annually). An account over 31 days with a balance pending is your responsibility and we request you follow up with your insurance company. Accounts over 60 days will be subject to our collection agency for further legal processing.

Additionally, our practice may charge you for appointments that you do not keep and for appointments that you do not cancel within 24 hours business day notice. Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

_____	_____	_____
PRINT NAME (PATIENT)	SIGNATURE OF RESPONSIBLE PARTY	DATE

Assignment of Benefits
For the office of
Hollymead Dental Arts

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
- We require you to pay the estimated copayment, which is the amount not covered by your insurance company at the time we provided service to you. The copayment is only an estimate of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are receiving within 30 days from the time of billing. If your insurance company has not made payment to our practice within 30 days, we will ask you to pay the entire balance at that time. You will be responsible for seeing reimbursement from your insurance company at that time.
- Our practice does not guarantee that your insurance company will pay for treatment that you receive from our practice. We perform routine billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

WE DO NOT FILE WORKMANS COMP.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO HOLLYMEAD DENTAL ARTS.

PRINT NAME (PATIENT)	SIGNATURE OF RESPONSIBLE PARTY	DATE

HIPAA ACKNOWLEDGEMENT/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 (HIPAA). 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 uses and disclosures of my protected health information and my rights under HIPAA. I understand that
you reserve the right to change the terms of 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.

Print Patient Name _____
Signature _____
Signature Date _____
Relationship to Patient (if patient unable to sign) _____

I give my permission for my protected health information to be disclosed for purpose of communicating results, findings, and care decisions to the individuals listed below. I understand I can add or remove any individuals at any time.

Name	Relationship	Phone number