Children's Dentistry of Morristown

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Child's Name _____( ) Male ( ) Female

Date of Birth _____ Child's Age _____ Nickname _____

Address _____

City _____State _____ Zip Code _____

Home Phone _____Cell Phone _____Work Phone _____

E-Mail _____

Have your brothers and sisters been seen in this office? _____

If yes, Name & Ages of Brothers & Sisters _____

Who shall we thank for referring you to our office? _____

Child's Physician/Pediatrician _____

Address & Phone _____

Date of last Medical Exam _____ Are all immunizations up to date? _____

Is your child taking any medications? _____

Has your child ever had any unusual reactions to any medications? _____

MEDICAL HISTORY

__ Allergies _____

__ADD/ADHD __Convulsions __Immune Disorders __Psychiatric Evaluations __Seizures __Pregnancy __Diabetes __Cancer
__Past Hospitalizations ___Autism ___PDD __Heart Problems __Brain Injury __Glandular Problems __Kidney Problems __HIV
__Rheumatic Fever __Bleeding Disorders __Asthma __Liver Disease __Respiratory Disorder __Heart Murmur____ Other _____

NOTE: It is VERY important for the health of your child that medical clearance for heart murmur/problems be documented

DENTAL HISTORY

What is the chief reason for this visit? _____

Has your child received dental care before? _____ If yes, explain _____

Has your child experience any major injury to the jaw or face? _____ If yes, explain _____

Does your child have any of the following? (Please circle all that apply)
Thumb Sucking Finger Sucking Pacifier Mouth Breathing Nail Biting Lip Biting
Was your child breast/bottle fed? Breast _____ Bottle_____ To what age? _____

Does/did you child fall asleep with a bottle or while nursing? _____

How often does your child brush? _____

Has your child ever had a fluoride treatment? _____

Is your child taking a fluoride supplement? If so, which one? _____

FINANCIAL INFORMATION

PARENT INFORMATION

Name _____

Address _____

City/St/Zip _____

Home Phone _____

DOB _____

SS# _____

Employer _____

Address _____

City/St/Zip _____

Work Phone _____

Dental Ins _____

Group # _____

Primary _____ Secondary _____

PARENT INFORMATION

Name _____

Address _____

City/St/Zip _____

Home Phone _____

DOB _____

SS# _____

Employer _____

Address _____

City/St/Zip _____

Work Phone _____

Dental Ins _____

Group # _____

Primary _____ Secondary _____

CONSENT FOR TREATMENT

I certify that the above information is true and correct. I also, give consent for my child to be examined and receive dental treatment as the dentist deems fit after consultation with the parent.

Patient who carry dental insurance understand that all dental services furnished are charged directly to the patient and the he/she is personally responsible or payment of all dental services.

A service charge of 1.5% per month (18% per annual) on the unpaid balance will be charged on all accounts exceeding 60 days unless previously written financial agreements are satisfied.

A $75 fee will be incurred for missed appointments without 24 hour notice.

I understand that payment is expected for services at the time it is rendered unless previous arrangements have been made or within five (5) days of billing if credit shall be extended.

I grant permissions to your assignee to telephone me at home or work to discuss matters related to this form.

Signature _____Date _____

Relationship to Patient _____

(Name of Practice)

ACKNLOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement [1]

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, by acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

INSERT DISCLOSURE INFORMATION

This form is education only does not _____ legal advice and _____ only federal, _____

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