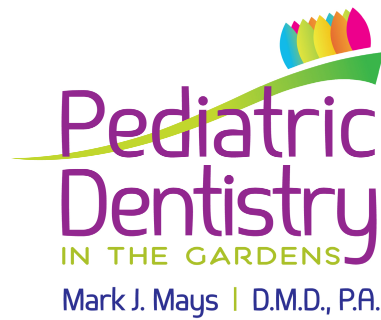


Health History Form

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

____

Please Note: Whoever brings the child to the appointment is responsible for payment at the time of the visit.

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:

- ○ Hearing Difficulties
- ○ Speech Difficulties
- ○ Emotional Difficulties
- ○ Eye Problems
- ○ Liver problems or Hepatitis
- ○ Rheumatic Fever
- ○ Diabetes
- ○ Bleeding Problems
- ○ Anemia
- ○ Asthma
- ○ Skin Problems
- ○ Heart Problems/Murmur
- ○ Kidney Problems
- ○ ADHD/ADD
- ○ Autism
- ○ Cancer
- ○ Muscle Weakness
- ○ Epilepsy or Seizures
- ○ Cerebral Palsy
- ○ Sickle Cell Anemia
- ○ Disease(s) Affecting normal Growth
- ○ Bone or Joint Problems
- ○ Birth Defects
- ○ HIV +/Aids
- ○ Tuberculosis
- ○ Other_________________________
- ○ 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

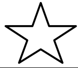
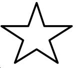
Please help us serve you better by keeping scheduled appointments. Due to an unusual amount of broken appointments, we do now reserve the right to charge for appointments broken without 24 hours advance notice and in certain cases will be forced to dismiss the patient from our practice.

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 herby 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: _____________________