



We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.



PATIENT INFORMATION (for patients age 18 and under)

TODAY'S DATE _____

Legal Name of Minor/Child _____ Home Phone _____
(Please write full name as shown on Birth Certificate or Insurance Card)

Sex M F Age _____ Birthdate _____ Nickname _____ Social Security # _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Name of School _____ City _____ State _____

Person financially responsible _____ Home Phone _____ Work Phone _____

PARENT/GUARDIAN INFORMATION

Guardian's Name _____ Relationship to Patient _____

Mailing Address _____
(if different from patient's) Street City State Zip

Home Phone _____ Work Phone _____
(if different from above) (if different from above)

Cell/Beeper # _____ Home Fax # _____

Employer _____

Social Security # _____ Birthday _____

Drivers License # _____ State _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what reason? _____

Has child complained about dental problems? Yes No Any injuries to mouth, teeth, head? Yes No

Does child brush teeth daily? Yes No Does child grind teeth? Yes No

Does child use floss every day? Yes No Does child bite lips or cheek? Yes No

Does child suck his/her thumb? Yes No Does child have bleeding gums? Yes No

Does child bite his/her nails? Yes No Has child had orthodontic treatment? Yes No

Does child have a problem with mouth breathing? Yes No Any unhappy dental experience? Yes No

Does child use a pacifier? Yes No If yes, explain _____

Is fluoride taken in any form? Yes No _____

MEDICAL INFORMATION

The following information is to be reviewed by the doctor and will be held in the strictest confidence. It is important that you complete this medical history form in its entirety so that we may accurately diagnose and treat your child/minor, according to their general health and well being. If you have any questions or require assistance in completing this medical history form please ask our staff to help. Please return this completed form to the receptionist. Thank you for allowing us to serve your dental needs.

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

Weight _____ Height _____

Is minor/child under care of physician now? Yes No If yes, what kind _____

Ever been hospitalized? Yes No Is there excessive bleeding when cut? Yes No

If yes, explain _____ Has patient ever had a blood transfusion? Yes No
If yes, when? _____

Ever had surgery?..... Yes No How long ago? _____

Medications _____

Allergies _____

Women: Are you Pregnant? Yes No If yes, when is your due date? _____

Name of OB Doctor _____

Phone # _____



DOES MINOR/CHILD HAVE OR HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✓)

- | | | | | |
|--|---|---|--|--------------------------------|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes, Type I or II | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Rheumatic Fever | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sinus Problems | |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Disease | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis | |

In the event of an emergency please specify one person not living in your household for us to contact if parents are unavailable:

Name _____ Relationship to patient _____

Home Phone _____ Work Phone _____ Cell Phone _____

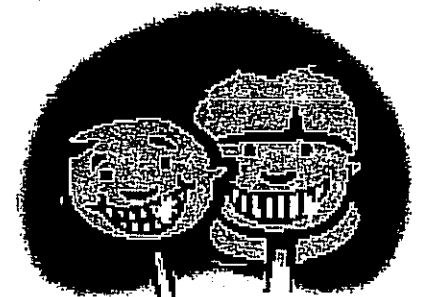
Whom may we thank for referring you? _____

or - How did you hear about us?

Newspaper Sign Yellow Pages Brochure Other _____

Signature of Parent/Guardian _____

Date _____



MINOR / CHILD CONSENT

I, _____ being the parent &/or guardian of _____

_____, a minor (age 18 and under), do hereby request and authorize the dental office, inc. and it's staff to perform necessary dental services for my minor/child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, and to do whatever procedures that the judgment of the doctor may dictate during treatment.

I understand that payment for dental treatment, if applicable to me, is due on the date of service. The dental office, inc. does not carry balances or offer credit due to the size and volume of patients that they service and to keep their fees reasonable.

There may be times that I cannot accompany my minor/child to their dental appointments. I may send them with a family member or friend. Furthermore, my young adult, if applicable, may drive themselves to their dental visit. In the event that I cannot accompany my minor/child for their dental visit I authorize the doctors and/or staff of the dental office to do whatever treatment may be necessary to improve my minor/child's dental health.

I also agree that, if any payment is due to the dental office, inc. for services rendered at the time of service, I will not send my minor/child unprepared to pay for your services. If payment cannot be made on the date of service, I will call to Reschedule the appointment until which time the payment can be available.

*** I agree to the following in regard to Payment for services rendered on this minor/child :
(Please check one)**

- Does not apply to me or my minor/child
- I agree to accompany my minor/child to each dental visit
- I will send Cash with my minor/child or guardian
- I will send a Signed Check with my minor/child or guardian
(my drivers license is on file as ID)
- I hereby authorize the dental office, inc. to keep the following Credit Card # on file
& To be used to pay for dental treatment on the above noted minor/child :
Type of Card: MC Visa Debit Am Express Discover
Card # _____ Exp Date: _____
- I agree to call the dental office before the day of the appointment to give them a credit card # over the phone to be used for that visit only.

My signature below is for Consent / Authorization on today's services & any and all Future dental services as needed for the above named minor / child.

X _____
Signature of Parent or Guardian

Date

THIRD PARTY BILLING

I understand as dental providers, the dental office, inc. cannot do third party billing. If this is required due to divorce, separations, etc. the responsible party must be in our office in person to sign the billing paperwork. **Otherwise, the adult who brings the child into our office will be the responsible party.** Please make arrangements with the third party before future appointments are scheduled.

If the services are in relation to a workman's comp claim or an accident, pre-approval is required in all cases except emergency. The patient is responsible for furnishing all information needed to file claims or the case will be considered payment in full at the time of service. If for any reason service is not paid in full by workman's comp or accident insurance, the balance will be billed to the responsible party. Any claims not paid by the insurance carrier within ninety (90) days will be billed to the responsible party for payment in full. We will provide the documentation necessary to follow-up on and for reimbursement of funds paid to our office for said claim.

X

Signature of Parent, Guardian or Responsible Party

Date



(205) 640-1717 FAX 640-5197 2323 MOODY PARKWAY Moody, AL 35004

RECORDS RELEASE AUTHORIZATION

Date of Request : _____

My permission is granted to _____ located at
Name of Dental Office / Doctor

Address _____ City _____ St _____ Zip _____

and whose telephone number is () _____ to disclose to

THE DENTAL OFFICE, INC. the complete information concerning the dental / medical

findings & treatment of _____ - / /
Print Name of Patient Birthdate

Including but not limited to:

1. Dental Panorex X-ray (dated within last 5 yrs)
2. Dental BiteWing X-rays (dated within last 2 yrs)
3. Any Pictures (photos) and/or Disketts / CD's Regarding dental findings
4. Complete Charting by the Doctor and/or Hygienist (Including Periodontal charting)

I hereby release you, the doctor and the staff from any laws related to disclosure of confidential or privileged information.

Thanking you in advance for your cooperation in regards to this matter.

Signature of Patient/Guardian : _____

The Dental Office, Inc.

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use & disclosure of your protected health information to carry out treatment, payment activities & healthcare operations.

Date: _____

Patient Name : _____ Date of Birth : _____

Patient Address : _____

SSN : _____ Most Reliable Phone # : _____

The Privacy Act generally requires healthcare providers to take responsible steps to limit the use of disclosure of and requests for protected health information to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of protected health information disclosures. Information provided below, if completed properly, will constitute an adequate record.

Note : Uses & Disclosures for protected health information may be permitted without prior consent in an emergency.

I give The Dental Office, Inc. permission to release medical/dental information to the following persons:
(Please check all that apply and list first & last name)

<input type="checkbox"/> None	<input type="checkbox"/> Spouse _____
<input type="checkbox"/> Parents _____	<input type="checkbox"/> Guardian _____
<input type="checkbox"/> Mother (only) _____	<input type="checkbox"/> Father (only) _____
<input type="checkbox"/> Child (only) _____	<input type="checkbox"/> Other _____

ACKNOWLEDGMENTS:

I acknowledge that I have received the Notice of Privacy Practices from The Dental Office, Inc. I understand that this organization reserves the right to change its Notice of Privacy Practices in which case a revised Notice of Privacy Practices will be issued.

Print Name of Patient

Signature of Patient

Print Name of Personal Representative

Signature of Personal Representative

Relationship of Personal Representative to Patient

FOR OFFICE USE ONLY

Acknowledgment could not be obtained because :
(Check those that apply)

Patient Refused to Sign
 Prohibited by Communication Barriers
 Prohibited due to an Emergency Situation
 Other (please specify)