I. Patient Information

Patient's First Name_____Middle_____Last_____
Preferred Name_____Sex_____Date of Birth_____
Hobbies_____
Child lives with: ☐Both parents ☐Mother ☐Father ☐ Stepmother ☐Stepfather ☐Grandparent
☐Other_____
Any siblings who are patients here? Yes or No If yes, names: _____
Patient's Address_____Home Phone #_____
City/State/Zip_____

Mother/Guardian's Full Name_____
Address_____Date of Birth _____
Home #_____ Cell #_____ Work # _____
Email address_____
Where Employed_____Occupation_____

Father/Guardian's Full Name_____
Address_____Date of Birth _____
Home #_____ Cell #_____ Work # _____
Email address_____
Employed_____Occupation_____

Collins Children's Dentistry

Whom may we thank for referring you to our office? _____
(Please enter full name of doctor, school, or person)

Preferred contact method: ☐Email ☐Text ☐Phone ☐ Mail

The closest relative or friend not residing with patient who we may contact in case parents cannot be reached.

Name_____Cell #_____ Home #_____

Reason for bringing child to the dentist_____

As Parent or Guardian of the above child, I give my consent to needed dental services and use of proper & acceptable methods to complete dental exam. I also accept responsibility of payment of the services provided for my child. For the safety of your child, please remain in the office during your child's visit in case you are needed by our staff.

_____ _____
Parent or Guardian Date

FOR PATIENTS COVERED BY DENTAL INSURANCE

PRIMARY CARRIER

Insurance Company Name: _____
Group #_____ID#/SSN: _____
Billing Street Address: _____
City: _____ State: _____ Zip: _____
Policy Holders Name: _____
DOB: _____Relationship to Child: _____
Employer: _____

SECONDARY INSURANCE

Insurance Company Name: _____
Group #_____ID#/SSN: _____
Billing Street Address: _____
City: _____ State: _____Zip: _____
Policy Holders Name: _____
DOB: _____Relationship to Child: _____
Employer: _____

Patient Name_____ **Date of Birth**_____

II. Medical History

Child's Physician_____ Phone_____

Date of last exam_____

☐Yes ☐No Is your child allergic to any medicines or food? If yes, what? _____

_____

☐Yes ☐ No Is your child taking any medications? If yes, what? _____

_____

☐Yes ☐No Has your child ever been hospitalized or had an operation? If yes, explain _____

_____

☐Yes ☐No Does your child have any physical, mental, emotional, muscular, or special needs? If yes, explain_____

_____

☐Yes ☐No Does your child have any hearing, sight, speech or learning issues? If yes, explain _____

_____

☐Yes ☐No Does your child need an antibiotic prescription recommended by your physician, for a heart condition-artificial valves/shunts, etc.) before any dental work?

Please check any that pertain to your child

☐ADD/ADHD
☐Allergies
☐Autism
☐Asthma
☐Bleeding Disorder/hemophilia
☐Cancer
☐Cerebral Palsy
☐Developmental delay
☐Diabetes
☐Eczema/Skin Disorders
☐Epilepsy/Seizures
☐Heart/Cardiovascular Condition
☐Heart Murmur
☐Hepatitis
☐HIV/AIDS
☐Latex Allergy
☐Liver/Kidney Problem
☐Malignant Hyperthermia
☐Obstructive Sleep Apnea
☐PABA Allergy
☐Preterm Birth? Child Intubated_____
☐Rheumatic Fever
☐Sickle Cell Anemia
☐ MTHFR gene mutation

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III. Dental History

☐Yes ☐No Is your child experiencing dental pain today? If so, where_____

☐Yes ☐No Is this your child's first visit to the dentist?

If not, how long has it been since the last visit to the dentist? _____

Name of previous dentist_____

☐Yes ☐No Were any x-rays taken?

☐Yes ☐ No Has your child experienced an unfavorable reaction from previous dental care?

☐Yes ☐ No Does your child have a thumb, finger, or pacifier habit? (circle)

☐Yes ☐ No Do you have well water?

☐Yes ☐No Does your child take fluoride supplements?

☐Yes ☐No Does your child take a bottle at night?

How often does your child brush their teeth? _____Floss_____

How often do you clean your child's teeth? _____

I have read my child's medical history dated and confirm that it accurately states past & present conditions. I will notify immediately if there are any changes. Signature_____Date_____

Date	Changes	Parent's Signature	Reviewed by

HIPAA Compliance Patient Consent Form

Child's Name _____ Date of Birth _____

Collins Children's Dentistry Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health/dental information is used and disclosed. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare/dental information. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- • □Protected health/dental information may be disclosed or used for treatment or payment.
- • □The practice reserves the right to change the privacy policy as allowed by law.
- • □The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- • □The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.

May we phone, email, or send a text to you to confirm appointments? Yes No
May we leave a message on your answering machine at home or on your cell phone? Yes No
May we discuss your child's dental condition with any member of your family? Yes No
If YES, please name the members allowed and their relationship to the child:

_____

_____

_____

May we give appointment date information to your child's school? Yes No

IF YES, school name _____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Date	Changes to original HIPAA Compliance Patient Consent Form