We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in creating your beautiful smile!

Patient Information

Name: ____ Date of Birth: __________________

Preferred Name (nickname):____________________________ Male: _____ Female: _____

Whom May We Thank for Your Referral: ____

Address: ____

City: ________________________________ State: _______ Zip:______________

Last Check-up/Cleaning: ____/____/____ Home Telephone: (____)_______-_______

Responsible Party Information

Mother/Guardian Name: ____ Date of Birth: _____/_____/_____

Social Security: ________-_______-_________ Employer: ____

Address: ___________________________________City: _________________State: ______ Zip:_ ___________

Home Telephone: (_____) ______-_______ Work: (____) ______-_______ Cell: (____) ______-_______

Email: ____

Father/Guardian Name: ____ Date of Birth: _____ /_____/______

Social Security: _______-_______-________ Employer: ____

Address: ______________________________________City: _________________State: ______ Zip: __________

Home Telephone: (_____) _______-________ Work:(____) ______-_______ Cell:(_____) ______-_______

Primary Insurance Coverage

Primary Insured Name: ____ Date of Birth: _____/______/______

Relationship to Patient: ____________________________________ ID#: __________________________________

Employer: ______________________________________ Address: ______________________________________

Name of Insurance: _____________________________________ Group Number: _________________________

Address: ____ Telephone: (____) ______-______

Secondary Insurance Coverage

Secondary Insured Name: ____ Date of Birth: _____/______ /______

Relationship of Patient: ___________________________________ ID#_____________________________________

Employer: _____________________________________ Address: ____

Name of Insurance: _____________________________________ Group Number: __________________________

Address: ____ Telephone: (_____) ______-______

Health History

Purpose of today's dental examination? ___________________________________

•Personal

Name____ Date of Birth_____________________ Age_________

Is your child adopted? ☐ Yes ☐ No If yes, does your child know? ☐ Yes ☐ No

Physician's Name____________________________________ Telephone_______-________-________

Family Dentist___________________________________ Name of child's school__________________________________

•Child's Dental History

Has child seen a dentist before? ☐ Yes ☐ No Where:____

If yes, approximate date of last visit__________________

Unfavorable experiences in a dental or medical office? ☐ Yes ☐ No

if yes, please explain:____

How often does your child brush teeth?__________________________ Do you help? ☐ Yes ☐ No

How often does your child floss?________________________________ Do you help? ☐ Yes ☐ No

•Medical History

☐ Yes ☐ No AIDS/HIV
☐ Yes ☐ No Allergies to latex
☐ Yes ☐ No Anemia
☐ Yes ☐ No ADD/ADHD
☐ Yes ☐ No Bladder Problems
☐ Yes ☐ No Cancer
☐ Yes ☐ No Cerebral Palsy
☐ Yes ☐ No Premature
☐ Yes ☐ No Hospital stays or operations
☐ Yes ☐ No Cleft Lip/Palate
☐ Yes ☐ No Developmental Delay
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Heart Problems
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Jaundice
☐ Yes ☐ No Stomach problems
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No Trauma to mouth/face
☐Yes ☐ No Tuberculosis
☐ Yes ☐ No Blood Disorders

Other____

-Is your child currently taking any medication? ☐ Yes ☐ No If yes, list names and purpose ___________________________

-Does your child have any breathing problems? ☐ Yes ☐ No ___________________________

-Breathes primary through: ☐ Nose ☐ Mouth ___________________________

-Does your child snore? ☐ Yes ☐ No

-Is your child taking any supplemental fluoride? __ *Tablets* __ *Drops* __ *Water* __ *Vitamins*

•Allergic or reactions to any of the following? ___ None

___ Aspirin ___ Local Anesthetics ___ Sulfa Drugs
___ Antibiotics ___ Metal ___ Barbiturates Sedatives

Other:____

•Habits

Child have any of the following habits?

-Thumb or Finger sucking ☐ Yes ☐ No - Nail biting ☐ Yes ☐ No -Teeth grinding ☐ Yes ☐ No

-Pacifier use ☐ Yes ☐ No -Biting or sucking lip ☐ Yes ☐ No

-Did your child use a bottle? ☐ Yes ☐ No If yes, when did child stop? ____________________________

-Does your child currently use a bottle? ☐ Yes ☐ No If yes, how often during the day?________________________

•Family Dental History

*Mother*___ *Father*___ had a lot of decay
*Mother*___ *Father*___ have periodontal disease
*Mother*___ *Father*___ had orthodontic care
*Mother*___ *Father*___ have TMJ problems

Authorization

The information that I have given is correct to the best of my knowledge. I understand that I will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my child. I certify that the patient is covered by insurance with **:_________________.** I assign directly to Eastlake Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that responsibility for payment for dental services provided in the office for my child is mine, due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize Eastlake Pediatric Dentistry to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any changes in my child's insurance coverage.

Signature:____**Date**:___________________________________

PATIENT 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:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
2. Obtaining payment from third payers (e.g. my insurance company)
3. 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 an 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.

Date ___________________________

Print Patient Name: ____

Relationship to Patient: ____

Print Name of Parent/Guardian: ____

Signature of Parent/Guardian: ____