happy teeth
LEVITTOWN

PATIENT INFORMATION FORM

TODAY'S DATE: _____

1. TELL US ABOUT YOUR CHILD

Child's Name: _____

Preferred Name or Nickname: _____

Gender: ☐ Male ☐ Female

Childs Birthdate: _____/_____/_____ Age: _____

Home Phone #: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Child's SS#: _____

Referred By: _____

2. WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____

Relationship to the Child: _____

Do you have legal custody of the child? ☐Y ☐N

Is the child adopted? ☐Y ☐N

Is the child in a foster home? ☐Y ☐N

3. MOTHER'S INFORMATION

Name: _____

☐Mother ☐Stepmother ☐Guardian Birth date: ____/____/_____

SS#: _____ DL#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Work #: _____

Email Address: _____

Preferred Contact method ☐Home# ☐Cell# ☐Email

4. FATHER'S INFORMATION

Name: _____

☐Father ☐Stepfather ☐Guardian Birth date: ____/____/_____

SS#: _____ DL#: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell #: _____ Work #: _____

Email Address: _____

Preferred Contact method ☐Home# ☐Cell# ☐Email

5. PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Birth date: ____/____/_____

SS#: _____ DL#: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____

Cell #: _____

Employer: _____

6. DENTAL INSURANCE INFORMATION

Insurance Company: _____

Claims Address: _____

City: _____ State: _____ Zip: _____

Ins Co Phone #: _____

Group #: _____ ID #: _____

Name of Insured: _____

Relationship to Patient: _____

SS# of Insured: _____

Birth Date of Insured: _____

Insured's Employer: _____

7. PLEASE READ AND SIGN BELOW

All payments are due at time of service. However, most insurance plan benefits can be used for treatment in our office. Please check with your insurance plan administrator for more details. **During your visit, we will collect what we estimate your insurance will not pay. Actual insurance reimbursement may vary from our estimate. You are responsible for the full balance on your account.** In the case of divorce or separation the parent that brings the child in for the visit is responsible for payment at the time of the visit. Please see our insurance specialist or business manager with any questions.

I have read and understand this insurance policy and hereby authorize my insurance company to send payments directly to Happy Teeth and understand that I am responsible for all remaining balances.

Signature: _____ Date: ____/____/____

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8. MEDICAL HISTORY

Child's Name: _____

Child's Physician: _____

Address: _____

Phone Number: _____

Date of Last Visit: _____

Does your child take any medications? ☐Y ☐N
If yes, please list medications and include dosage:

_____

Are immunizations up to date? ☐Y ☐N
Has your child been treated in an emergency room? ☐Y ☐N
If yes, please explain: _____

Has your child been hospitalized or had surgery? ☐Y ☐N
If yes, please explain: _____

Has your child ever had any of the following conditions?

☐Y ☐N Heart Murmur
☐Y ☐N Rheumatic Fever
☐Y ☐N Artificial Heart Valves
☐Y ☐N Congenital Heart Defect
☐Y ☐N Scarlet Fever
☐Y ☐N Cancer/Tumors
☐Y ☐N Chemotherapy
☐Y ☐N Jaw Problems (TMJ/TMD)
☐Y ☐N Hearing/Visual Problems
☐Y ☐N Heart Problems
☐Y ☐N Seizures/Epilepsy
☐Y ☐N Tonsillitis
☐Y ☐N Respiratory Problems
☐Y ☐N Asthma/Difficulty Breathing
☐Y ☐N Seasonal Allergies
☐Y ☐N Blood Transfusion
☐Y ☐N Leukemia
☐Y ☐N Anemia
☐Y ☐N Diabetes
☐Y ☐N Hypoglycemia
☐Y ☐N Hemophilia
☐Y ☐N Abnormal Bleeding
☐Y ☐N Cleft Lip/Palate
☐Y ☐N Birth Defects
☐Y ☐N High Blood Pressure
☐Y ☐N Low Blood Pressure
☐Y ☐N Thyroid Problems
☐Y ☐N Sickle Cell
☐Y ☐N Hepatitis
☐Y ☐N Artificial Bones/Joints
☐Y ☐N Liver/Kidney Problem
☐Y ☐N HIV/AIDS
☐Y ☐N Tuberculosis (TB)
☐Y ☐N Hyperactive/ADD
☐Y ☐N Autism
☐Y ☐N Behavioral Problems
☐Y ☐N Mental/Physical Delay
☐Y ☐N Pregnancy

Allergic to:

☐Y ☐N Latex
☐Y ☐N Tetracycline
☐Y ☐N Penicillin/Amoxicillin
☐Y ☐N Food Allergies
☐Y ☐N Aspirin

Other: _____

9. DENTAL HISTORY

Previous Dentist: _____

Date of last exam: ___/___/___ Date of last x-rays: ___/___/___

Reason for today's visit: ☐Exam ☐Consultation ☐Emergency

How often does your child floss? _____

How often does your child brush? _____

Who brushes your child's teeth? _____

Is your child bottle fed or breast fed? _____

Does your child take fluoride supplements? ☐Y ☐N

Is your child's water fluoridated? ☐Y ☐N

Please check any of the following that apply to your child:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or Popping Jaw
☐ Food Collection Between Teeth
☐ Grinding Teeth
☐ Loose Teeth or Broken Fillings
☐ Injury to Face or Mouth
☐ Sensitivity to Cold/Heat
☐ Sensitivity to Sweets
☐ Sores or Growth in Mouth
☐ Mouth Breathing
☐ Thumb/Finger Sucking
☐ Pacifier Sucking
☐ Lip Biting
☐ Nail Biting

10. PLEASE READ AND SIGN BELOW

I affirm that the information I have given on this form is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status.

Signature: _____ Date: ___/___/___

Dr. Signature: _____ Date: ___/___/___

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General Consent for Treatment

Our office specializes in the dental health of children. We strongly believe in the establishment of a dental home for your child for preventive dental care in a safe and comfortable environment. In order to provide the best dental care, we are required to obtain your consent before preforming any dental services for your child. Please read this form carefully and we encourage you to ask us about anything that you do not understand, we will be happy to explain it to you.

I hereby authorize and direct Happy Teeth, with the support of licensed dentists and/or dental auxiliaries to perform upon my child the following dental treatment or oral surgery procedures including necessary or advisable local anesthesia, radiographs (x-rays), photographs or diagnostic aids. In general terms, the dental procedures may include one, or a number of, the following:

1. **Cleaning of the teeth and application of fluoride**
2. **Application of sealants to the grooves of teeth**
3. **Treatment of diseased or injured teeth with dental restorations**
4. **Stainless steel crowns**
5. **Extraction (removal) of one or more teeth**
6. **Treatment of diseased or injured oral tissues (hard and/or soft)**
7. **Treatment of malposed (crooked) teeth and/or developmental abnormalities with fixed or removable orthodontic appliances**
8. **Behavior guidance through the use of mouth prop, tell-show-do method, and/or voice control**
9. **Protective stabilization including holding my child or the use of a papoose board**
10. **Use of sedation medications and/or nitrous oxide to control apprehension**
11. **Space maintainer(s) to prevent shifting of teeth**

The treatment has been explained to me and I understand that none of the above procedures will be preformed without discussing the necessity with me and obtaining my consent to proceed. Alternative methods of treatment, if any have been explained to me, along with their advantages, disadvantages and risks. I am advised that good results are expected; however, the possibility and nature of complication cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I further understand and authorize the doctor to preform any necessary treatment that in his/her judgment will be in the best interest of my child's health, once treatment has been initiated.

Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgery procedures, medication and/or anesthetics. We are required to disclose the known risk of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, or scarring. I understand and accept that complications may require medical assistance, hospitalization and in very rare cases death.

I hereby state that I have read and fully understand this consent. I have been given an opportunity to ask questions regarding this consent and proposed treatment and understand that treatment and available options will always be discussed with me in detail prior to commencing work. I also understand that this consent will remain in effect until such time that I choose to terminate. Such termination of consent must be in writing.

Patient Name:_____ Date:_____

Signature of Parent or Guardian:_____ Date:_____

Witness:_____ Date:_____

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GENERAL OFFICE POLICIES

A parent/legal guardian must accompany each child to all dental visits. Only a parent/legal guardian can consent to treatment or fill out a child's medical history.

PARENT PARTICIPATION

Parents are welcome to accompany their child for exam and cleaning appointments. **Parents are encouraged to wait in the waiting room while their child is receiving treatment**. At subsequent visits we encourage that you allow our staff to accompany your child through the dental experience. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome apprehension. There are instances when a parents presence is needed during treatment, this will be evaluated on an individual patient basis.

SCHEDULED APPOINTMENTS

We attempt to schedule appointments at your convenience and whenever time is available. Preschool children and school children requiring extensive dental treatment are best seen in the morning when they are fresher and well rested because they tend to be more cooperative, which allows for a more comfortable experience for the child. In order to allow the best possible care for our patients, we reserve a specific time for your child and make every effort to see him/her as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. **However, if you need to change your child's appointment, it is required that a 48-hour notification is made to our office. If this requirement is not met, a possible charge of $25.00 will be added to your account.**

PAYMENT RESPONSIBILITY

All payments are due at the time of service. However, most insurance plan benefits can be used for treatment in our office. Please check with your insurance plan administrator for more details. **During your visit we will collect what we estimate your insurance will not pay. Actual insurance reimbursement may vary from our estimate. You are responsible for the full balance on your account. In the case of divorce or separation the parent that brings the child in for the visit is responsible for payment at the time of the visit. Please see our insurance specialist or business manager with any questions.**

X-RAY RECORDS

By law, x-rays taken here are the property of this office. **If for some reason you may need a copy of your x-ray records, a $25 processing fee will be required prior to delivery of the x-rays.**

THANK YOU FOR CHOOSING HAPPY TEETH AS YOUR CHILD'S ORAL HEALTHCARE PROVIDER.

I have read and understand these policies and hereby authorize my insurance company to send payments directly to Happy Teeth and understand that I am responsible for all remaining balances.

Patient's Name: _____

Parent/Guardian Signature: _____

Date: _____ Witness: _____

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NOTICE OF PRIVACY FORM

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of Happy Teeths' HIPAA Notice of Privacy Practices.

_____
Print Patient's Name

_____ _____
Signature of Patient Date

OR

_____
Signature of Personal Representative

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other _____

Please Note: It is your right to refuse to sign this acknowledgement.

I tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:

☐ *An emergency prevented us from obtaining acknowledgement*

☐ *A communication barrier prevented us from obtaining acknowledgement*

☐ *The individual was unwilling to sign*

Other: _____

_____

_____ _____
Staff Member Signature *Date*