

Child Health/Dental History Form



American Dental Association
www.ada.org

Patient's Name LAST FIRST INITIAL			Nickname	Date of Birth
Parent's/Guardian's Name			Relationship to Patient	
Address PO OR MAILING ADDRESS CITY STATE ZIP CODE				
Phone Home Work			Sex M <input type="checkbox"/> F <input type="checkbox"/>	
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? If you answer yes to any of the three items above, please stop and return this form to the receptionist.				
Has the child had any history of, or conditions related to, any of the following:				
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell
<input type="checkbox"/> Thyroid				
<input type="checkbox"/> Tobacco/Drug Use				
<input type="checkbox"/> Tuberculosis				
<input type="checkbox"/> Venereal Disease				
<input type="checkbox"/> Other _____				
Please list the name and phone number of the child's physician:				
Name of Physician _____			Phone _____	

Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. <input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____		
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. <input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized?	6. <input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. <input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic?	8. <input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?	9. <input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?	10. <input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?	11. <input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired?	12. <input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut?	13. <input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses?	14. <input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. <input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past?	16. <input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed?	17. <input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth?	18. <input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth?	19. <input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment?	20. <input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water		
22. Does the child take fluoride supplements?	22. <input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used?	23. <input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. <input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier?	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities?	27. <input type="checkbox"/>	<input type="checkbox"/>

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: Medical Alert Premedication Allergies Anesthesia Reviewed by _____
Date _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name: _____
 Male Female Married Single Child Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____

(Cell): _____ Best time to call: _____

Address: _____
Street Apartment #

City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Phone: _____ Ext: _____

Dental Insurance Information

Primary

Name of Insured: _____ is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____
Last First MI

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Brushin' on Belmont
2007 W. Belmont Ave., 1E
Chicago, IL 60618
(773)281-9800

PATIENT HIPAA 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:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- 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 and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

In understand that I may revoke this consent, in writing, at any time. However, any used or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature _____ Date _____

Relationship to Patient _____

Brushin' on Belmont
Robert A. Govoni D.D.S
Pediatric Dentistry

2007 West Belmont Ave., Suite 1E
Chicago, IL 60618
773.281.9800

We'd like to take this opportunity to welcome you to our practice and to familiarize you with our office billing policies. Please take a moment to read the following information then sign the sheet and return it to the front desk.

Our Financial Policies

Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan that fits your timetable and budget, and gives your child the best possible care. We accept cash, personal checks and most major credit cards. For more extensive procedures, a payment plan can be set up through Care Credit, an independent finance company, with 0% interest for six months.

DENTAL INSURANCE:

Our pediatric dental services are "in-network" with the following insurance PPO's: **Ameritas, Principal and Delta Dental Premier**. All other insurance companies do not provide pediatric specialist fees and therefore are considered "out of network".

If you have dental insurance, please provide the front desk with all of your information. If we have received a copy of your dental insurance the day of your child's appointment, we will be happy to file the claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount that insurance is not expected to pay.

For restorative procedures (fillings, crowns, nerve treatments, extractions) we will require 50% of the expected procedure fee. On average, most "out of network" insurance PPO's will provide coverage for 50% of the procedure fees. In the case of an overpayment, you will be refunded the difference immediately. If the insurance covers less than 50%, you will be responsible for the difference.

If you have not paid your balance within 60 days, you agree to pay a finance charge of 1.5% per month until the balance on your account has been paid.

Please understand that we file insurance as a courtesy to our patients. We are not responsible for how your insurance company handles your claims or for what benefits they pay on a claim. If you would like to know exactly what your insurance will pay for a given procedure, we can submit a pre-estimate of benefits to your insurance carrier. On average, it takes 3 weeks for them to return to us an estimation of benefits. At that time we will have a much better understanding of what your out of pocket costs may be.

COLLECTIONS:

If your account becomes past due, we will take all the necessary steps to collect the debt. If your account needs to be sent to a collection agency you agree to pay any and all costs that we incur, including attorney fees and court costs.

Appointment Cancellation Policy

At Brushin' on Belmont, appointments are made in advance by reserving the appropriate time slots to accommodate you, the patient, and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing and arranging the set up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on. We, therefore, require at least **48 hours** notice prior to canceling or rescheduling appointments.

Patients, who cancel or reschedule their appointment without a proper notice, will be charged a cancellation fee of **\$50.00 per hour of scheduled appointment**.

If two broken /missed appointments or cancellations occur without proper notice, the office reserves the right to NOT schedule any subsequent appointments and advise the patient to seek an alternate dental provider.

We thank you in advance for your cooperation with our administrative policies.

I acknowledge that I have been informed and given a copy of the Financial and Cancellation policy for the office of Brushin' on Belmont.

Signature of Patient (or parent/guardian if a minor)

Date