



BEARDEN FAMILY DENTISTRY

CHILD PATIENT WELCOME FORM

Welcome to your new dental home. The information on this form is important for our records and for your health. This information is strictly confidential. Thank you.

PERSONAL INFORMATION

Child's Legal Name: _____ Date of Birth: _____ Boy Girl

Child's Nick Name: _____ Home Phone #: _____

Child's Address: _____ City: _____ State: _____ Postal Code: _____

Social Security Number: _____ Referred By: _____

Who is accompanying the Child today: _____ Do you have Legal Custody: Yes No

Parent/Guardian's Name: _____ Address: _____

Parent/Guardian's Employer: _____ Occupation: _____

Work Address: _____ Work Phone #: _____

Parent/Guardian Driver's License #: _____ Date of Birth: _____

Child's School: _____ Child's Grade: _____

Do you have other family members who are patients here? _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

INSURANCE AND FINANCIAL INFORMATION

Does this child have Dental Insurance? No Yes - Insurance Company: _____ Phone # _____

Insured Name: _____ SS#: _____ Subscriber's Relationship to Child Parent Guardian

Insured Birthdate _____ Group Cert/ID # _____ Division # _____ Group/Policy # _____

Insurer Employer (if different from above) _____ Employer Address _____

Do you have secondary coverage? No Yes - Insurance Company: _____ Phone # _____

Insured Name _____ SS# _____ Subscriber's Relationship to Child Parent Guardian

Insured Birthdate _____ Group Cert/ID # _____ Division # _____ Group/Policy # _____

Employer (if different from above) _____ Employer Address _____



CHILD PATIENT WELCOME FORM

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RESPONSIBLE PARTY

Name of person responsible for this account _____ Relation to Child _____

Address: Street, Ste # _____ City _____ State _____ Postal Code _____ Phone # _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

RELEASE INFORMATION

You may discuss my health care with.....

Health Care Providers Yes No Insurance Companies Yes No Others (Spouse, Parents, etc.) _____

ASSIGNMENT AND RELEASE

- ❖ We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications, further disease, and misunderstandings. Therefore, if a plan is agreed upon and started, it should be completed.
- ❖ Dental insurance is designed to help aid in attaining optimum dental health; it is not designed to be a 'pay-all'. It is in your best interest to be sure that we have all of your current insurance information on file. We will do our best to answer any questions you have and are happy to process your claim forms at no charge.
- ❖ We schedule your appointments to your convenience, and your punctuality is appreciated. If you need to reschedule your appointment, please provide us with two working days' notice, in which case no cancellation fee will be applied. **No show or last-minute cancellations without approved circumstances will result in a \$75 cancellation fee.**
- ❖ I understand that I am responsible for payment of services rendered and that payment is due in full at the time of treatment unless prior arrangements have been approved. In the event payments are not received when agreed upon, 1.5% per month interest and if necessary, collection and/or legal fees of 50% will be added to the balance due. I hereby authorize release of any information, either in print or electronic media, including the diagnosis and records of treatment or examination rendered, to my insurance company.
- ❖ I hereby authorize payment directly to BEARDEN FAMILY DENTISTRY for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
- ❖ I authorize the above doctor and/or any provider or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature Parent/Guardian _____ Date _____

Witness Signature _____ Date _____



CHILD DENTAL / MEDICAL HISTORY

PERSONAL INFORMATION

Child's Name: _____ Child's Date of Birth: _____

DENTAL INFORMATION

What is the reason for your child's visit? Full Exam Emergency Consultation

Is your child in pain? Yes No If yes, for how long and in what area? _____

Child's Former Dentist _____ City, State _____ Last Dental visit date _____

Date of child's last Oral X-rays _____ Do you help your child floss and how often? _____

How often do you help your child brush? _____ Does your child require premedication? Yes No

Is your water at home fluoridated _____ What would you like to improve? _____

Check all that apply:

Bad Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Loose teeth or broken filling	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lip/mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tooth Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw, head or neck injuries	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw clicking and/or pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lip and cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No		

MEDICAL INFORMATION

Physicians Name: _____ Date of Last Visit: _____

Are you currently under medical treatment? Yes No If yes, for what? _____

Has your child ever taken Ritalin? Yes No If yes, for how long? _____ What is the child's blood type? _____

Does your child do any of the following? Thumb / Finger Sucking Tongue Thrusting / Sucking Heavy Snoring

Mouth Breathing Lip Sucking / Biting

Have you had an allergic reaction to any of the following?

Local Anesthetics Yes No

Penicillin or other Antibiotics Yes No

Sulfa Drugs Yes No

Barbiturates and/or Sedatives Yes No

Sleep Apnea Yes No

Lodine Yes No

Aspirin Yes No

Latex Yes No

Is your child currently taking any medications? Yes No If yes, please list: _____

Please list any other surgeries or medical conditions your child has ever had: _____

MEDICAL INFORMATION - continued

Please mark any that apply:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting/Dizzy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with surgery/extractions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of feet/ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Fatigue Synd.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough-persistent	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor/growth on head	<input type="checkbox"/> Yes <input type="checkbox"/> No
Taken Bisphosphonates	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Human Papilloma Vaccine	<input type="checkbox"/> Yes <input type="checkbox"/> No

- ❖ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and Parent/Guardian.
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Please advise us in the future of any change in your dental or medical history or any medications you may be taking.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____



**COVID-19 Pandemic
Dental Treatment Consent Form**

Even after following protocols set by the American Dental Association and our state's dental association, it is still possible to contract COVID-19 while at a dental office. We are following all guidelines to minimize the risk of transmission.

- I knowingly and willingly consent to have dental treatment completed during the COVID-19 pandemic. I understand that the COVID-19 virus has a long incubation period during which carriers of this virus may not show symptoms and may still be highly contagious. _____ (Initial)
- I understand that – due to the frequency of visits of other dental patients, the characteristics of the COVID-19 virus, and the characteristics of dental procedures – I have an elevated risk of contracting the COVID-19 virus simply by being in a dental office. _____ (Initial)
- I confirm that I am not presenting any of these COVID-19 symptoms: _____ (Initial)
 - Fever
 - Shortness of breath
 - Dry cough
 - Runny nose
 - Sore throat
- I confirm that I have not been in contact with a person who has been diagnosed with COVID19 within the past 14 days. _____ (Initial)
- I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least six feet for a period of 14 days to anyone who has recently traveled, and this is not possible with dentistry. _____ (Initial)
- I verify that I have not traveled outside the United States in the past 14 days. _____ (Initial)
- I verify that I have not traveled domestically within the United States by commercial airline, bus or train within the past 14 days. _____ (Initial)

Printed name: _____
(Patient)

Date of birth: _____
(Patient)

Signature: _____
(Patient or legal guardian)

Today's date: _____



Acknowledgment: Receipt of Notice of Privacy Practices

I have received a copy of the *Notice of Privacy Practices* from:

Practice Name

Effective Date

Patient Acknowledgment

Patient Name (Please Print)

Patient Signature

Effective Date

Personal Representative Acknowledgment

I am the personal representative of:

Patient Name (Please Print)

I have received a copy of the *Notice of Privacy Practices* from:

Practice Name

Personal Representative Signature

Effective Date

Personal Representative (Please Print)

Relationship to Patient



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:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my care).
- 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 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.

Patient or Legal Representative Signature

Signature of patient or legal representative

Date

Printed name of legal representative

Relationship to patient

I certify that I have the legal authority under federal and state laws to make this request on behalf of the patient identified above.

Signature of patient or legal representative

Date