Sunshine Pediatric Dentistry of Evansville

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Child's Name:_____ Nickname:_____ Sex: (M) (F) Birth Date:___/___/___

Address: _____
Street City Zip

Mother (full name)_____ Father (full name)_____

Mom Cell #: ( )_____ Mom Work #: ( )_____ Dad Cell #: ( )_____ Dad Work #: ( )_____

Home Phone #: ( )_____ Email:_____

Purpose of visit:_____ Concerns:_____

Name and age of siblings:_____ Is your child adopted? Y N

Does your child have any special needs?_____ Any phobias? _____

Child's school:_____ Who can we thank for referring you to us? _____

HEALTH HISTORY

Child's Pediatrician:_____ Kaiser # (if applicable)_____ Last Physical:___/___/ Phone #: ( )_____ Pediatrician's Address: _____

Is your child under a physician's care now? Y N If yes, reason:_____ Immunization up to date? Y N

Current Medications? Y N If yes, please list: _____

_____ Allergic to medication? Y N If yes, please list: _____

Does your child have an allergic reaction to any of the following: (please circle) Foods Pollen Dust Latex Eggs Soy Other_____?

Has your child had a history or difficulty with any of the following:

TMJ Problems	Y N	Premature Birth	Y N	Speech Disorder	Y N	Diabetes	Y N
Bleeding	Y N	Sinus Problems	Y N	Brain Injury	Y N	Allergies to Medications	Y N
Liver/Jaundice	Y N	Hepatitis	Y N	Tuberculosis	Y N	Ear aches/Infections	Y N
Heart	Y N	Immune Disorders	Y N	Bruising	Y N	Rheumatic Fever	Y N
ADHD/ADD	Y N	Cancer/Malignancies	Y N	Seizures	Y N	Autism	Y N
Down's Syndrome	Y N	Depression/Anxiety	Y N	Arthritis	Y N	Kidney	Y N
Cerebral Palsy	Y N	Delayed Development	Y N	Hearing	Y N	Asthma	Y N
Bone Disorder	Y N	Nosebleeds	Y N	Bladder	Y N	Last Asthma Attack: _____	
Eating Disorder	Y N	Emotional/School Problems	Y N	Snoring	Y N	Other: _____	

If YES to any of the above, please explain: _____

DENTAL HISTORY

Is this your child's first dental visit? Y N If no, previous dentist:_____ Phone number: ( )_____

Date of last visit:_____ How was his/her experience?_____ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: _____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: _____

Does your child have any of the following habits?: (please circle)

Thumb/Finger Pacifier Nail Biting Lip Sucking Mouth-breathing Snoring Teeth Grinding Nursing Bottle-feeding

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N Does your child use fluoridated toothpaste? Y N

How often does your child brush his/her teeth? x/day How often does your child floss? x/day With adult supervision? Y N

How may we help to make this visit a positive experience for your child? _____

Please continue to the back side…

A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY YOUR CHILD ON THIS FIRST VISIT.

GENERAL INFORMATION

Mother's Date of Birth: ___/___/___ Mother's Social Security Number: _____ Mother's Driver's License #: _____

Father's Date of Birth: ___/___/___ Father's Social Security Number: _____ Father's Driver's License #: _____

Parents are: (please circle) Married Divorced Single Widowed Partners Child lives with: (please circle) Mother Father Legal Guardian

Person financially responsible for child's dental care: _____

Father's Employer: _____ Occupation: _____

Employer Address: _____

Mother's Employer: _____ Occupation: _____

Employer Address: _____

Emergency Contact: _____ Address: _____ Phone: ( ) _____

INSURANCE INFORMATION

Do you have dental insurance coverage for your child? Y N

Father's Dental Insurance Company: _____

Insurance Phone #: ( ) _____ Insurance ID #: _____ Group or Policy Number: _____

Mother's Dental Insurance Company: _____

Insurance Phone #: ( ) _____ Insurance ID #: _____ Group or Policy Number: _____

I hereby give the dentist permission to complete an oral exam and radiographs (x-rays) for diagnostic purposes. I understand this visit will include a cleaning and fluoride treatment, as well. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

I hereby authorize the dentist to release any information including diagnosis and records to the third-party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. This office is not responsible for any insurance company's arbitrary determination of payment, which procedures are covered under the plan, frequency of procedures performed, or period of time taken to process claims. You are responsible for payment in full regardless of any insurance you may have. As a courtesy to you, we will complete and file insurance forms relative to dental treatment and will do our best to collect all fees due from your insurance carrier. However, fees not paid by your insurance company within 60 days are due and payable by the patient's parent or guardian. I realize that the failure to keep this account current may result in the dentist being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month will be applied to unpaid balances over 60 days past due and where appropriate, a credit bureau report may be obtained. In case of default on payment of this account, I agree to pay the collection costs and reasonable attorney fees incurred in attempting to collect on this account of any future outstanding account balances. I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

Responsible Party Policy:

Because of a large percent of the population involves a divorce situation, it is the policy of this office to collect from the parent who brings the child in for dental services.

Office Policies:

Unless appointments are cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. We do attempt to confirm appointments, but do so only as a courtesy. The Parent/Guardian is ultimately responsible for any scheduled appointments made for the child.

I acknowledge that I have read and agree to the above policies.

SIGNATURE: _____ Relationship: _____ Date: _____

Acknowledgment of receipt of NOTICE OF PRIVACY PRACTICES (HIPAA)

You may refuse to sign this portion of the acknowledgment

I, _____ have received a copy of or have had the opportunity to review this office's NOTICE OF PRIVACY PRACTICES (HIPAA).

Print Name: _____ SIGNATURE: _____ Date

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