Patient Acquaintance Form

Child's Legal Name:_____ **Nickname**:_____ **DOB**:_____
Gender Identity: M/F/Other (*please specify*):_____**Pronouns**: He, Him, His/She, Her, Hers/They, Them, Their
School:_____ **Grade**:_____ **Email**:_____
Child's Home Address:_____ **City**:_____ **State**:_____ **Zip**:_____
Parent's Marital Status: Married Separated Divorced Remarried Widowed Single
Mother's Information Name:_____ DOB: _____ SSN:_____
Address (*if different than child*): _____ City:_____ State:_____ Zip:_____
Spouse's Name (*if different than father*):_____ Email Address:_____
Employer:_____ Cell:(____)_____ Work:(____)_____
Father's Information Name:_____ DOB:_____ SSN:_____
Address (*if different than child*):_____City:_____ State:_____ Zip:_____
Spouse's Name (*if different than mother*):_____ Email Address:_____
Employer:_____ Cell:(____)_____ Work:(____)_____
Preferred Pharmacy / Pharmacy Address: _____

Medical History

Pediatrician:_____ **Other Specialists**:_____
Does this patient have any health issues (*if yes please list*):_____
Y N Are any pre-medications required for dental or medical treatment?
Y N Is there any significant birth history?:_____
Y N Has your child had any surgeries or hospitalizations? (*Please specify with approx. dates*)**:**
_____
Y N Does your child have any allergies to foods or medications? (*Specify*): _____
Y N Does your child take any medications? (*Please list all including vitamins*):_____
Y N Does your child have any emotional/behavioral or learning disorders?:_____

Dental History

Does your child presently have any of the following habits? (circle one): If habit stopped, at what age?:_____
☐ Pacifier ☐ Thumb Habit ☐ Finger Habit ☐ Lip Biting ☐ Nail Biting ☐ Grinding
Has your child had a toothache recently? Y N
Do you have any concerns about your child's mouth? Y N
Is this your child's first visit to the dentist? Y N *If no, where was their previous dentist?* _____
Has your child been to an orthodontist? *If yes, whom?*:_____
Does your child have any speech issues? (*please explain*):_____
Does your child play any sports? Y N If yes, do they wear an athletic mouth guard? Y N

Oral Health Habits

Does your child receive fluoride in any of the following forms?
☐ Water ☐ Toothpaste ☐ Tablets ☐ Rinses ☐ Drops ☐ Other_____
What kind of toothbrush does your child use? (*circle one*) **Manual Electric**
How often does your child brush each day?: _____ **Does your child floss? Y N** *If yes, how often?*: _____
When do you assist your child? : Morning Night Not Assisting
Please list kinds of snacks your child enjoys: _____

Form Completed By: _____

Signature:_____ **Date**:_____

Office Financial Policy

In an effort to prevent any misunderstanding, we have set forth the following financial policy:

1. Full payment is expected at the time of service unless other written arrangements have been made and agreed upon prior to your appointment.
2. The copay presented on the day of service is just an estimate and is subject to change. In the event there is an outstanding balance after the claim is processed, you are responsible for all charges whether or not paid by insurance.
3. If an appointment is broken or cancelled with less than 24 business hours' notice, a $25.00 charge per appointment will be applied to your account.
4. A deposit will be required to reschedule appointments after two or more consecutive cancellations of the same appointment. The deposit will be applied to copay if patient arrives to the appointment or will be forfeited if cancelled or broken again.
5. It is understood and agreed that in the event that any outstanding balance has to be referred to a collection agent or attorney for recovery, the patient will be fully responsible for any costs, including but not limited to attorney's fees. **A social security number is required on a family file** in the case we need to refer to collection agency.

Name of Responsible Party _____ **Social Security Number** _____
Please list full name of each family member that you are responsible for:
_____

Please fill out the following information if you have Dental Insurance:

(Please make sure that all information is accurate and complete. A social security number is required to process claims. It will greatly expedite the processing of your claim. Thank You.)

Primary Insurance Information:

Policy Holder Name _____ Date of Birth _____
Name of Insurance Company _____Subscriber ID Number & SSN _____
Employer _____ Group Number _____
Insurance Co. Phone Number _____
List of dependents covered under primary insurance plan
_____

Do you have dual dental insurance? (Please check one) **Yes** _____ **No** _____

Secondary Insurance Information (If applicable):

Policy Holder Name _____ Date of Birth _____
Name of Insurance Company _____Subscriber ID Number & SSN _____
Employer _____ Group Number _____
Insurance Co. Phone Number _____
List of dependents covered under primary insurance plan
_____

Please print name and sign below to indicate that you have fully read and understand our financial policies.

Print Name _____

Signature _____ **Date** _____

Acknowledgement Form Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). The Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information
2. The right to request corrections to your information
3. The right to request that your information be restricted
4. The right to request confidential communication
5. The right to a report of disclosures of your information
6. The right to a paper copy of this notice

We want to assure you that your medical/protected health information is secure with us. The Notice contains information about how we will ensure that your information remains private.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have received a copy of this practice's NOTICE OF PRIVACY PRACTICES. I understand that if I have questions or complaints regarding my privacy rights that I may contact the office directly. I further understand that the practice will offer me updates to the NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way.

_____ _____

Print name **Signature**

_____ ☐ Patient refused to sign

Date