Patient Information and Medical History

972.608.4746
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Child Legal Name: _____ Preferred Name: _____

Date of Birth _____/_____/_____ Age: _____ Weight: _____ ☐ Male ☐ Female

Home Address: _____ Apt. # _____

City: _____ State: _____ Zip code: _____

School: _____ District: _____ Grade: _____

Have sibling(s) been seen in this office? ☐ Yes ☐ No

Name(s) of sibling(s): _____

***WHOM MAY WE THANK FOR REFERRING YOU TO US?**

☐ Pediatrician/Doctor ☐ Friend

☐ Internet ☐ Other

Name: _____

EMERGENCY CONTACT (other than parents)

Name: _____

Relationship: _____

Phone #: _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone #_____

Mailing Address: _____City: _____ State: _____ Zip: _____

DENTAL HISTORY

What is the reason for your child's dental visit? _____

Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____

Name of previous dentist: _____ Phone: _____

☐Yes ☐No Has your child experienced any unfavorable reaction from previous dental care?
Explain:_____

☐Yes ☐No Does your child suck a finger, thumb, or pacifier?

☐Yes ☐No Does your child have pain when chewing, yawning, or wide opening?

☐Yes ☐No Does your child go to bed with a bottle or sippy cup?

☐Yes ☐No Does your child snack frequently? What are their favorite snack(s) foods? _____

☐Yes ☐No Has your child had local anesthetic? Were there any problems? _____

☐Yes ☐No Has your child been sedated for dental treatment? Were there any problems?
Explain (if yes) _____

☐Yes ☐No Have your child's teeth ever been injured? Which teeth: _____
Dental treatment for trauma: _____

Please check if your child is having problems with the following:

☐Cavities ☐Toothache ☐Sensitive Teeth ☐Mouth Breathing ☐Trauma
☐Gum Infections ☐Color of Teeth ☐Jaw Sounds ☐Grinding of Teeth

Comments:

_____

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MEDICAL HISTORY

Is your child allergic to:

☐ Penicillin ☐ Latex ☐ Aspirin ☐ Local Anesthetic (Lidocaine)
☐ Foods: _____ ☐ Other (including OTC)_____

☐ Yes ☐ No Is your child in good health? Date of last physical exam _____
☐ Yes ☐ No Has your child ever had a health problem? _____
☐ Yes ☐ No Are your child's immunizations current?
☐ Yes ☐ No Is your child currently taking any medications? Please list medication, dose & reason:
_____
☐ Yes ☐ No Have you ever been told that your child needs to take antibiotics before dental treatment?
☐ Yes ☐ No Has your child ever been hospitalized, had general anesthesia, or emergency room visits?
Explain: _____

Do you consider your child to be:

☐ advanced in the learning process
☐ progressing normally
☐ slow in the learning process

Please check if your child has been treated for any of the following:

☐ Abuse	☐ Cancer/Tumors	☐ Heart Murmur	☐ Recurrent herpes/fever blisters
☐ ADD/ADHA	☐ Cerebral palsy	☐ Hepatitis	☐ Rheumatic fever
☐ AIDS	☐ Cleft lip/palate	☐ Kidney Disease	☐ Seizures
☐ Anemia	☐ Congenial birth defects	☐ Liver/GI Disease	☐ Sickle cell disease/trait
☐ Anxiety Disorder	☐ Diabetes	☐ Mental Delays	☐ Significant Injuries
☐ Arthritis	☐ Endocrine	☐ Personality Disorder	☐ Snoring
☐ Asthma/Breathing	☐ Eyesight	☐ Social Disorder	☐ Speech/Hearing
☐ Autism	☐ Frequent Infections	☐ Physical Delays	☐ Tonsil/Adenoid Problems
☐ Bleeding/transfusions	☐ Heart Disease	☐ Recurrent Headaches	☐ Tuberculosis

Other:

_____

If any boxes checked, please describe further:

_____

CONSENT FOR DENTAL TREATMENT

I certify that I have read and understand the above information on this form to the best of my knowledge. All questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I also understand it is very important to report any changes in my child's medical or dental status to the dentist at the earliest possible time, and I agree to do so.

I give consent for Grin Central Station LLP to perform dental treatment on my child.

I understand I will be responsible for any charges incurred for my child for dental treatment.

Signature _____ Date _____

Relationship to Patient: _____

Family and Insurance Information

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Parent/Legal Guardian 1: _____Relationship to Patient _____

Date of Birth ____/____/_____ Social Security _____-_____-_____

Cell Phone # _____ Work Phone # _____

Email _____

Address (if different from child's) _____

_____

Occupation _____ Employer _____

Parent/Legal Guardian 2: _____Relationship to Patient _____

Date of Birth ____/____/_____ Social Security _____-_____-_____

Cell Phone # _____ Work Phone # _____

Email _____

Address (if different from child's) _____

_____

Occupation _____ Employer _____

DENTAL INSURANCE INFORMATION

Dental Insurance? ☐ Yes ☐ No

Policy Holder's Name _____ Date of Birth _____

Relationship to Patient _____

Employer Name _____

Dental Insurance Company Name _____

Policy Holder ID# or SS# _____ Group # _____

Insurance Phone _____

Insurance Mailing Address _____

____ (Initials) grin pediatric dentistry is an **OUT OF NETWORK** provider. This means that grin pediatric dentistry does not have any contract with any insurance companies.

____ (Initials) *Since this patient is a minor, it becomes necessary that a signed permission be obtained from the parent or legal guardian before any dental service can be performed. Authorization is hereby granted as such.*

____ (Initials) **I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform grin pediatric dentistry/ Grin Central Station LLP of any changes.**

Legal Guardian's Signature: Date:

_____ _____

Relationship to Patient: _____

Financial Agreement

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Thank you for choosing us for your child's dental care. Dr. Ryan and the staff of Grin Pediatric Dentistry have been specially trained to provide comprehensive dental care for your child (ren) in a fun and educational environment. To minimize administration costs, we ask that you be aware of the following:

A. **Insurance:** *Your insurance coverage is a contract between you, your insurance company, and your employer**. We are not a part of the contract.*** We will be happy to bill your primary insurance carrier for you; however, any co-insurance and any non-participating insurance will be due in full at the time of service. Although we attempt to estimate your portion due at the time of service, **this is only an estimate!** The exact full amount can only be determined after the receipt of insurance payments. You are responsible for filing any secondary insurance claims. In the event that your dental plan determines a service to be "not covered" you will be responsible for the complete charge. In that event we will bill you, and payment is due upon receipt of that statement. _____(Initials)

B. **Missed Appointments:** Appointments are reserved in advance for your child (ren). We require that you give us a 24-hour advance notification for any scheduling change, because your child's individual appointment time with the Doctor impacts the medical and dental health of our other patients. Missed appointments will be charged at the rate of **$50.00.** _____(Initials)

C. **Returned Checks** will be subject to a $28.00 processing fee. Please be advised that if your check is returned to us for non-sufficient funds we will only accept Cash and or Credit thereafter. _____(Initials)

D. **Divorce:** In case of divorce or separation, the **parent requesting treatment** for the child will be held accountable for any charges for services rendered, regardless of a divorce decree. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the **requesting parent's** responsibility to collect from the other parent after settling their account with Grin Central Station LLP/grin pediatric dentistry. _____(Initials)

I have read and fully understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____
Signature of Responsible Party Date

_____
Please Print Name of the Patient

grin pediatric dentistry
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSD AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPPA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information.

If you sign a Consent Form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

- Health care operations include the business aspects of running out practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or health care operations in the following circumstances:

- In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment:

- If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent; or

- If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstance.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Patient Information Authorization

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This form is to be completed for any other person bringing the child/children in for their dental appointments other than the natural mother or father or legal guardian.

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

Patient Name _____ Birthdate _____

I give Grin Central Station LLP permission to discuss the indicated aspects of my account with the following person(s).

(Please check all that apply)

___Can consent to (sign consent) and discuss recommended treatment

___Can schedule appointments

___Can discuss financial arrangements

___Can discuss information related to insurance coverage and payments

___Can discuss completed treatment

1. _____ _____
(Print name) (Relationship to patient)

2. _____ _____
(Print name) (Relationship to patient)

3. _____ _____
(Print name) (Relationship to patient)

Signature _____ Date _____
(Natural mother or father or legal guardian)

This authorization will remain in effect until it is revoked in writing by the natural mother, father, or legal guardian listed above.

Continuous Authorization

Grin Central Station Dental LLP
972.608.4746

Grin Pediatric Dentistry is an OUT OF NETWORK provider. This means that Grin Pediatric Dentistry does not have any contract with any insurance company. Because of this, any charges that insurance does not pay will become your obligation to pay. _____ (Initials)

We prefer that arrangements for these balances be made ahead of time with use of a credit card on file.

I, _____, authorize Grin Pediatric Dentistry to retain my credit card on file as part of my dental record, for payment purposes only. After my dental insurance company has paid its portion of the dental services rendered to me at Grin Pediatric Dentistry. I, _____, hereby give my consent to Grin Pediatric Dentistry to charge any outstanding balance to my credit card on file. This balance may include deductibles, denials, and non-covered services.

I have been informed Grin Pediatric Dentistry will keep this signature on file for any estimated patient portion due at the time of service, and any outstanding balance after insurance payment. I understand that the amount I owe provided on my treatment plan is only an estimate and my actual financial obligation may be higher than anticipated depending on my insurance plan.

I understand I have the right to change my credit card information at any time, and I must notify Grin Pediatric Dentistry in a timely manner. I understand this form is valid without expiration until I give a 30-day written notice of cancellation to Grin Pediatric Dentistry.

**Would you like to receive a courtesy call to inform you when we are processing your card?*

_____ Yes _____ No

If yes, we will give you a courtesy call to let you know that there is a balance on your account and that we are processing your card. Please contact the office within 24 hours of this phone call if you would like your card processed on different day. If we do not hear back from you within 24 hours we will process your card.

Account #: _____

Responsible Party Name: _____ Relationship: _____

Credit Card Information:

___Visa ___MasterCard ___Discover ___Amex

Card Holder's Name: _____

Card #: _____ Exp. Date: _____

Address: _____ Zip Code: _____

Cell Phone #: _____ Work Phone#: _____

My signature below indicates I have read the above disclosure, and all information provided is accurate and complete. I agree to the terms of the One Time Authorization as provided above.

Responsible Party Signature: _____

Staff Initials _____ Date: _____ ___Copy to Patient, original filed

Patient Consent Form

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I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this form can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare provides who may be involved in that treatment directly and indirectly
- Obtain payment from third- party payers
- Conduct normal healthcare operations such as quality assessments and physician certification

I have been informed by the organization of their *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information have informed me. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry put treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken relying on this consent.

Patient(s) Name(s): _____

Legal Guardian Signature: _____

Relationship to Patient(s): _____

Date: _____