Little people's dental

Patient's Name_____Sex_____Preferred Name_____

Date of Birth_____How did you hear about our office?_____

MEDICAL HISTORY

Child's Physician_____Date of last exam _____

Is your child currently under the care of a physician besides well-child visits? **Y/N (If yes, for what?)**_____

Is your child currently taking any medications**? Y/N (If yes, what?)**_____

Has your child ever been hospitalized or had major surgery? **Y/N (If yes, for what and when)**_____

Does your child have any allergies to medicines, foods, or other materials? **Y/N (If yes, what?)**_____

Does your child have a history or diagnosis of any of the following:

	yes	no		yes	no		yes	no		yes	no
Heart trouble	□	□	Asthma	□	□	Liver Disease	□	□	Epilepsy	□	□
Heart murmur	□	□	Kidney Disease	□	□	Hepatitis	□	□	Deafness	□	□
Rheumatic Fever	□	□	Premature Birth	□	□	Anemia	□	□	Anaphylaxis	□	□
Seizures/Convulsions	□	□	Diabetes	□	□	Cancer	□	□	Cerebral Palsy	□	□
Bleeding problems	□	□	AIDS/HIV	□	□	Chemotherapy	□	□	Spina Bifida	□	□
Blood Disorders	□	□	Lung Disease	□	□	Radiation therapy	□	□	Hemophilia	□	□

If yes or other, please explain:_____

DENTAL HISTORY

Date of last dental exam_____For what service?_____Previous dentist _____

Has your child experienced any unfavorable reaction from previous medical or dental care? **Y/N (If yes, please explain)**

_____

Has your child had any past injury to head, face, or teeth? **Y/N(If yes, please explain)**_____

Has your child complained about a dental problem? **Y/N (If yes, what?)**_____

How often does your child brush?_____Is the brushing supervised? **Y/N** Do you floss your child's teeth? **Y/N**

Does your child use fluoride? **Y/N** **If yes, what kind: Drops □ Tablets □ Paste □**

Do you have any other concerns about your child that we should discuss? **Y/N(If yes, please explain.)**_____

AUTHORIZATION ***Please fill in completely and Initial (5 places) & Sign at bottom of page***

***INITIALS_____I have answered all of the previous questions to the best of my knowledge and understand the dentist will use this information to determine appropriate dental treatment for my children. I agree to notify the dentist of any changes in my child's health status immediately.

***INITIALS_____I hereby authorize the Doctors and staff of Little People's Dental to provide dental treatment for my children. I consent to such treatment, medications, and treatment methods as are deemed appropriate by the doctors and staff in providing the safest and best possible dental care for my children.

***INITIALS_____I hereby authorize Little People's Dental to release all information necessary to secure payment of benefits and authorize my insurance company to pay the benefits otherwise payable to me. I also authorize the use of my signature on all insurance claim submissions.

***INITIALS:_____I understand that I am responsible for payment of all services provided and that the office does insurance as a courtesy. I also understand that I am responsible to pay at time of service 100% of any services deemed by the dentist's office to be non-covered by insurance. I understand this is not a guarantee that the insurance will pay the balance of the services. In the event the insurance does not pay the estimated balance in full, I understand that I will be billed for the difference. I agree to an interest of 1.5% per month (18% per anum) on any unpaid balance. Some insurance companies pay less for white fillings on back teeth. We use only white fillings in our office. Any amount not covered by insurance is your responsibility. I also understand in the event of failure to pay the balance this account will be placed with a collection agency and I agree to pay an additional 50% plus all incurred legal fees to cover these expenses.

***INITIALS:_____**I understand that a $50 charge may be made for broken appointments unless the office is notified 24 hours in advance.**

Responsible Party_____**Date**_____

I certify that the above information has not changed.

Initials_____Date_____ Initials_____Date_____ Initials_____Date_____ Initials_____Date_____

FAMILY FINANCIAL AND HIPAA CONSENT (ONE PER FAMILY)

RESPONSIBLE PARTY(person signing paperwork; doesn't have to be the insurance policy holder)

Name_____ Date of Birth_____ Relationship to Patient_____

Social Security #_____ Sex_____ Employer_____

Home/Mailing Address_____ City_____ State_____ Zip_____

Contact info (for reminders):

Cell Phone#_____ Home Phone#_____ Other Phone#:_____

Patient lives with: mom □ dad □ grandparent □ guardian □ other □_____

preferred email address:_____

OTHER PARENT INFORMATION

Name_____ Date of Birth_____ Relationship to Patient_____

Social Security #_____ Sex_____ Employer_____

Home/Mailing Address_____ City_____ State_____ Zip_____

EMERGENCY CONTACT INFO (Someone other than immediate family)

Name_____ Relationship_____ Phone #_____

DENTAL INSURANCE INFORMATION (Please fill in completely and provide a copy of your card.)

Dental Insurance_____ Claims address_____

City_____ State_____ Zip_____ Phone #_____

Policy Holder's Name _____ **Date of Birth** _____ **Relationship to patient**_____

Social Security #_____ **Employer**_____ **Policy/ID #**_____ **Group #**_____

SECONDARY DENTAL INSURANCE INFORMATION (If applicable)

Dental Insurance_____ Claims address_____

City_____ State_____ Zip_____ Phone #_____

Policy Holder's Name _____ **Date of Birth** _____ **Relationship to patient**_____

Social Security # _____ **Employer**_____ **Policy/ID #**_____ **Group #** _____

Is there a court order stating who is responsible for insurance? Y/N If yes, who is responsible?_____

Medical Insurance Name_____ Phone #_____

Policy Holder_____ Medical Insurance Policy #_____

CONSENT FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This form authorizes us to use and disclose protected health information (PHI) for the purposes of healthcare operations, treatment and payment activities. Before signing, please read our Notice of Privacy Policies to gain a clear understanding of how we may use and disclose your protected health information. For further questions concerning our Notice of Privacy Policies, please contact our Office Manager. You may reach us by calling 801-446-8007 or writing to Little People's Dental at 1268 West South Jordan Parkway, Suite 101, South Jordan, Utah 84095.

CONSENT: Patient's Names:_____

Address:_____ City:_____ State:_____ Zip:_____

I, (GUARDIAN)_____, have read your Notice of Privacy Policies and I consent to your use of our personal health information for the purposes of healthcare operations, treatment and payment activities.

Signature:_____ Date:_____ Relationship to Patient:_____

****Acknowledgment of Receipt of Notice of Privacy Policies (attached to clipboard)****

I hereby acknowledge that I have received a copy of Little People's Dental Notice of Privacy Policies.

Name (print)_____ Signature:_____ Date:_____

Disclosures to Friends and/or Family Members

I give permission for my child's Protected Health Information to be disclosed for purposes of communicating results, findings, finances and care decisions to the family members and others listed below:

NAME	RELATIONSHIP	CONTACT NUMBER
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

Name (print)_____ Signature_____ Date_____