Pediatric Dentistry
OF SOUTH RIDING

Date_____.

PATIENT INTRODUCTION AND HISTORY

Please assist us by answering the following questions, which are important in evaluating and treating your child.

Patient History

Child's Name_____ Nickname _____

Age_____ Date of Birth _____Sex _____School_____Grade_____

Address _____
Street

_____
City State Zip

Phone (H) _____ (W) _____ (C) _____

Email_____

Reason for this visit_____

Referred or recommended to us by _____

Medical History

Childs physician _____ City _____ Phone _____

Last physician's visit_____ Seen for _____

	YES	NO
Is your child presently under care for any medical problems or condition?	☐	☐
What? _____		
Is your child currently taking any drugs or medications?.....	☐	☐
What? _____ Dose _____		
Has your child a history of any of the following?		
Congenital heart disease, heart murmur or heart damage from rheumatic fever.....	☐	☐
Blood disorders, bleeding problems, anemia or sickle cell disease.....	☐	☐
Seizure disorders, epilepsy, convulsions, cerebral palsy or brain injury.....	☐	☐
Sight or hearing disorders or limitations.....	☐	☐
Asthma, pneumonia, tuberculosis, cystic fibrosis or breathing difficulties.....	☐	☐
Stomach, intestinal, kidney or liver problems, including jaundice or hepatitis.....	☐	☐
Diabetes, thyroid disorders or other glandular problems.....	☐	☐
Immune system disorders, including HIV infection or AIDS.....	☐	☐
Cancer, tumors or growths.....	☐	☐
Joint or limb problems, including arthritis, or muscle problems or weaknesses.....	☐	☐
Allergies to any drugs or medications or to latex rubber.....	☐	☐
Allergies _____		
Are there other medical problems or conditions you feel should be brought to the doctor's attention.....	☐	☐
What?_____		

Growth and Developmental History

Was your child premature or low birth weight?…… ☐ ☐
Did nursing, bottle feeding or bottle habits continue beyond eighteen months of age?…….. ☐ ☐
Does (or did) your child have any oral habits beyond one year of age?…… ☐ ☐
☐ Thumb ☐ Fingers ☐ Blanket ☐ Pacifier ☐_____
☐ Still present ☐ Discontinued at age _____
Does your child have any learning disabilities, developmental delay or intellectual impairment?... ☐ ☐
` Does your child have any behavioral problems, attention disorders or communication problems?. ☐ ☐

Dental History

Is this your child's first dental visit?…… ☐ ☐
Previous dentist _____ City _____ Date of last visit _____ **YES** **NO**

Has your child had an unfavorable experience in a previous dental (or medical) office?…….. ☐ ☐
Are you aware of any current dental problems which you expect will require treatment?……. ☐ ☐
Has your child ever had a toothache or tooth pain? …… ☐ ☐
Has your child experienced injuries to the mouth, teeth or jaws (falls, blows, chips, etc.)?……... ☐ ☐
Do you have any concerns regarding tooth grinding?…… ☐ ☐
Does your child receive fluoride tablets, vitamins or other fluoride supplements?……..…… ☐ ☐
Has your child been seen or treated by an orthodontist?…… ☐ ☐
Name of orthodontist _____ City _____

THIS IS MY AUTHORIZATION TO DR. I-FANG TSAI, FOLLOWING EXPLANATION OF THE PROCEDURES, METHODS AND MEDICATIONS INVOLVED, TO PERFORM ALL NECESSARY DIAGNOSTIC, PREVENTIVE, RESTORATIVE, SURGICAL, ORTHODONTIC AND ASSOCIATED DENTAL TREATMENT FOR MY ABOVE-NAMED CHILD. THE INFORMATION I HAVE PROVIDED IS, TO THE BEST OF MY KNOWLEDGE, ACCURATE AND COMPELTE. I AUTHORIZE AND CONSENT TO THE RELEASE OF ALL INFORMATION CONCERNING MY CHILD'S DENTAL HEALTH AND TREATMENT HISTORY TO THIRD PARTY PAYERS AND TO OTHER HEALTH PROFESSIONALS. THIS CONSENT IS TO REMAIN IN EFFECT UNTIL CANCELLED IN WRITING.

Signature_____ Relationship to Child_____ Date_____

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FAMILY RECORD AND FINANCIAL RESPONSIBILITY

FAMILY RECORD

Name(s) and age(s) of children to be seen on initial visit:

_____

Please list the names and ages of any additional brothers and sisters:

_____

Have any family members been patients in our office in the past? If so, please list:

_____

Father's full name _____ Marital Status _____

Social Security number _____ DOB_____

Address _____

Occupation _____ Employed by _____

Address _____ City _____ Phone _____

Mother's full name _____ Marital Status _____

Social Security number _____ DOB _____

Address if different _____

Occupation _____ Employed by _____

Address _____ City _____ Phone _____

If family is not living together, person financially responsible for account _____

DENTAL INSURANCE INFORMATION

First Policy

Name of parent insured _____ Relation to child _____

Social Security # _____ Employee ID # _____ Birthdate _____

Insurance name _____ Employer _____ Group/policy # _____

Second Policy

Name of parent insured _____ Relation to child _____

Social Security # _____ Employee ID # _____ Birthdate _____

Insurance name _____ Employer _____ Group/policy # _____

Assignment of Benefits

I hereby authorize payment of insurance benefits otherwise payable to me directly to Dr. I-FANG TSAI. I understand that I am financially responsible for all charges not reimbursed by my insurance carrier(s). I authorize and consent to the release of dental and financial information necessary for the filing of insurance claims.

Signature _____ Date _____

THE INFORMATION I HAVE GIVEN IS, TO THE BEST OF MY KNOWLEDGE, ACCURATE AND COMPELTE. I UNDERSTAND THAT I AM REPOSNSIBLE FOR, AND AGREE TO THE PAYMENT, OF ALL CHARGES INCURRED IN THE OFFICE IN THE CARE AND TREATMENT OF MY FAMILY MEMBERS. IN THE EVENT THAT FINANCIAL RESPONSIBILITY CHANGES, I UNDERSTAND THAT I AM STILL RESPONSIBLE UNTIL NEW FINANCIAL RESPONSIBILITY IS ESTABLISHED AND ACCEPTED BY DR. I-FANG TSAI. IF PAYMENT OF ANY BALANCE IS NOT RECEIVED WITHIN 90 DAYS OF FIRST STATEMENT DATE, I AGREE TO PAY ANY AND ALL EXPENSES INCURRED BY PEDIATRIC DENTISTRY OF SOUTH RIDING AS A RESULT OF COLLECTION FEES DUE TO UNPAID BALANCES. THIS ACCEPTANCE OF FINANCIAL RESPONSIBILITY IS TO REMAIN IN FORCE UNTIL CANCELLED IN WRITING.

Signature_____ Date_____

Pediatric Dentistry of South Riding

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Dr. I-Fang Tsai and Pediatric Dentistry of South Riding will use and disclose the patient's personal health information for treatment and to receive payment for the care we provide and for other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your/your child's personal health information. The terms of the notice may change with time and we will always post the current notice at our facility, on our website, and have copies available for distribution.

I have reviewed the office's Notice of Privacy Practices.

_____

Please Print Name

X _____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign
[ ] Communications barriers prohibited obtaining the acknowledgement
[ ] An emergency situation prevented us from obtaining acknowledgement
[ ] Other (Please specify)

_____
_____
_____

Adapted from the American Dental Association HIPAA Privacy Kit for use only by a dentist, January, 2003
Revised: 11/24/2010
Pediatric Dentistry of South Riding