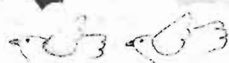
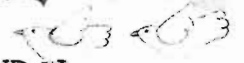




Patient ID No. ____________
Today's date ____________

Welcome to our practice!

We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your child

Child's Name ____________
Nickname ____________ Sex ____
E-mail ____________
Birthdate ____________ Age ____
SS#/SIN ____________
School ____________ Grade ____
Child's Home Address ____________
City ____________
State/Province ____________ Zip/Postal Code ____________
Phone ____________

Mother ☐ Stepmother ☐ Guardian

Name ____________
E-mail ____________
Home Phone ____________
Work Phone ____________
SS#/SIN ____________
Employer ____________
Occupation ____________

Father ☐ Stepfather ☐ Guardian

Name ____________
E-mail ____________
Home Phone ____________
Work Phone ____________
SS#/SIN ____________
Employer ____________
Occupation ____________

Parent/Guardian's Marital Status

☐ Single ☐ Married
☐ Divorced ☐ Widowed ☐ Separated

Who is responsible for making appointments?

Name ____________
E-mail ____________
Home Phone ____________
Cell Phone ____________
Work Phone ____________
Best time to call (time) ____________ (days) ____________

Responsible Party

Name ____________
E-mail ____________
Relationship ____________
Address ____________
SS#/SIN ____________

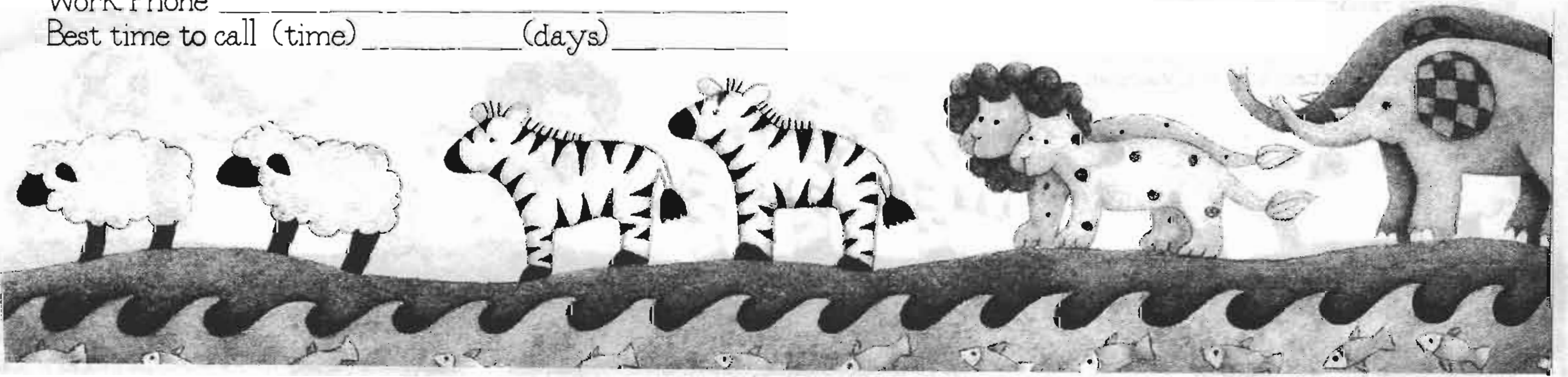
Primary Dental Insurance

Insured's Name ____________
Relationship ____________
Birthdate ____________ SS#/SIN ____________
Employer ____________ Date Employed ____________
Occupation ____________
Insurance Company ____________
Group No. ____________ Emp. No. ____________
Ins. Company Address ____________
Deductible ____________ Max. Annual Benefit ____________
Orthodontic Coverage ☐ yes ☐ no

Additional Insurance

Insured's Name ____________
Relationship ____________
Birthdate ____________ SS#/SIN ____________
Employer ____________ Date Employed ____________
Occupation ____________
Insurance Company ____________
Group No. ____________ Emp. No. ____________
Ins. Company Address ____________
Deductible ____________ Max. Annual Benefit ____________
Orthodontic Coverage ☐ yes ☐ no

over please



Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had any difficulty with previous visits?

Comments: ___________________________

Has your child ever had any of the following:

Asthma	☐yes	☐no
Cancer/Hepatitis	☐yes	☐no
HIV/AIDS	☐yes	☐no
Hemophilia	☐yes	☐no
Diabetes	☐yes	☐no
Allergies	☐yes	☐no
Rheumatic Fever	☐yes	☐no
Congenital Heart Defect	☐yes	☐no
Handicaps/Disabilities	☐yes	☐no
Convulsions/Epilepsy	☐yes	☐no
Tuberculosis	☐yes	☐no
Abnormal Bleeding	☐yes	☐no
Heart Murmur	☐yes	☐no

Type ___________________________

Persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ☐yes ☐no

Has your child ever taken Fen-Phen/Redux? ☐yes ☐no

Please explain any medical problems that your child has ___________________________

____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X ___________________________

Signature of patient's parent/guardian date

Child's Habits

How often does your child brush? ___________________________

How often does your child floss? ___________________________

Date of last dental visit ___________________________

Previous Dentist ___________________________

Child's Physician ___________________________

Phone Number ___________________________

Child's Birthdate ___________________________

Is your child's water fluoridated? ☐yes ☐no

Does your child take fluoride supplements? ☐yes ☐no

Does your child:

Suck thumb/finger	☐yes	☐no
Suck/bite lips	☐yes	☐no
Bite/chew nails	☐yes	☐no
Chew hard objects (pencils, etc.)	☐yes	☐no
Grind teeth	☐yes	☐no
Clench jaws	☐yes	☐no

Dentist's Review

____

____

____

____

Date ________ Signed Dr. ___________________________

Health History Update

Comments ___________________________

____

Date ________ Signature ___________________________

Comments ___________________________

____

Date ________ Signature ___________________________

Payment for Services

Patient Name ____

Our mission is to deliver high quality, cost-effective dental care to our patients. Following your diagnosis, the doctor will advise you of his recommendation for treatment. Our staff is here to help you with your insurance questions; however it is the patient's responsibility to know their coverage and limitations. Actual benefits are determined by your insurance company at time of service. We will discuss with you the estimated cost of today's and future treatments.

Payments for services are due at the time of treatment. If you have dental insurance, we will be happy to submit your claim for you. Your estimated out-of-pocket expense for all procedures is due at the time treatment is initiated.

We are sensitive to the fact that some patients may not be able to pay in full for their treatment; therefore, we do offer several alternative payment programs for your convenience.

1. Check or Cash – 5% discount
2. MasterCard, Visa, or Discover – NO discount
3. Dental Fee plan – Terms up to 60 months. Low fixed rates, no prepayment penalty, Interest free options available.
4. Medical Bureau – Terms up to 12 months. INTEREST FREE, with no service charge.

PLEASE INDICATE YOUR CHOICE OF PAYMENT BELOW:

_____ Cash or Check
_____ MasterCard, Visa, or Discover
_____ Dental Fee Plan*
_____ Medical Bureau*

*SUBJECT TO APPROVAL

24 HOURS NOTICE IS REQUIRED FOR CHANGING APPOINTMENTS. A BROKEN APPOINTMENT FEE OF $25.00 WILL BE APPLIED WITH LESS THAN 24 HOURS NOTICE.

X________________________________ Date______________________
Signature of Patient/Responsible Party

Over Please

ALCOMA DENTAL ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Alcoma Dental Associates to use and disclose health/dental information about you for treatment, payment, and health/dental care operations purposes.

Notice of Privacy Practices: Alcoma Dental Associates has a Notice of Privacy Practices, which describes how we may use and disclose your protected health/dental information and how you can access your protected health/dental information and exercise other rights concerning your protected health/dental information. You may review our current notice prior to signing this acknowledgement and consent.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health/dental information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Acknowledgement and Consent

I have read the Notice of Privacy Practices for Alcoma Dental Associates. Alcoma Dental Associates is authorized to use and disclose health/dental information about (patient name) __________________ for treatment, payment, and healthcare operation purposes consistent with its Notice of Privacy Practices, I understand by signing this form, I will consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations. This office will continue to use my health information in some of these ways: by calling me by my first name from your waiting room, by posting pictures of children in your "no cavities club", by mailing me reminder appointment cards with reason for visit, by reminding me of any pre-treatment medication if necessary, and by calling to confirm appointments, and by making my chart available for review by consultants or auditors as described in our Notice of Privacy Practices.

______________________________   ______________________
Patient or personal representative's signature   Date

______________________________   ______________________
Name of personal representative   Relationship to Patient (Or other authority)