



Happy Children Pediatric Dentistry

New Patient Information

PERSONAL

Patient's Name _____
Last First MI (Preferred Name)
Birthdate _____ Gender: M F
Parent's Name: _____
Work Phone _____ Wireless Phone _____
Email _____
Preferred contact method: _____ Work phone _____ Wireless phone
Student status if dependent over 19 (for ins) Nonstudent Fulltime Parttime
How did you hear about us?

(If someone referred you here, please write down their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family

Address _____
Address 2 _____
City _____ State _____ Zip _____
Home Phone _____

INSURANCE POLICY 1

Patient relationship to subscriber: Self Spouse Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____
Please present insurance card to receptionist.

INSURANCE POLICY 2

Patient relationship to subscriber: Self Spouse Child
Subscriber Name _____ Subscriber ID # _____
Insurance Company _____ Phone _____
Employer _____ Group Name _____ Group # _____



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MEDICAL HISTORY

Name of Medical Doctor: _____ City/State _____

Emergency Contact _____ Phone _____ Relationship _____

List all the medications or drugs you are now taking:

List all the medications or drugs you are allergic to:

[] None _____

[] None _____

Has your child had any issues with any of the following medical conditions? (Please Circle)

Allergies/ Seasonal	Depression	High Blood Pressure	Osteogenesis Imperfecta
Anemia	Diabetes Heart Disease	Hyperactivity/ADD/ADHD	Radiation Treatment
Anxiety	Dizziness	Immune Disorder	Rheumatic Fever
Aplilepsia	Ear Infection(s)	Infections (Viral/Bacterial)	Seizures
Arthritis	Eating Disorder	Jaundice	Shunts
Asthma/Reactive Airway Disease	Eczema	Kidney or Bladder Problems	Sickle Cell Disease
Autism	Emotional Problems	Learning Disorder	Sinus Problems
Behavior Problems	Endocrine or Hormonal Disorder		Skin Problems
Bipolar	Epilepsy	Lung(s)/ Liver Problems	Speech Problems
Bladder Problem	Eye(s)	Mental Retardation	Thyroid Problems
Bleeding Disorder	Fibromyalgia	Migraines	TMJ
Bone Disorder	Gastrointestinal Problems/Reflux		Transfusion
Brain Injury	Glaucoma	Muscular Disorder	Transplants
Bruising	H.I.V. Positive	Neurodermatitis Osteogenesis	Tuberculosis
Cancer	Handicaps/Disabilities	Panic Attack	Ulcers
Cerebral Palsy	Headaches	Pervasive Development Disorder	Other
Chronic Fatigue	Heart Murmur	PKU	
Cleft Palate	Hemophilia	Pneumonia	
Congenital Birth Defects	Hepatitis	Premature Birth	

Please Explain Other: _____

Dental History

Date of Last Visit: _____ Date of Last X-rays /Cleaning: _____

Is floss used at home? _____ Unusual reaction to dental injections? _____

Reason for today's visit: _____ Are you in pain? _____

Concerns for today's visit: _____



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FINANCIAL AGREEMENT

- * For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
- * I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
- * I understand that payment for services are due at the time the services are rendered. As a courtesy, Happy Children Pediatric Dentistry will attempt to ESTIMATE my insurance benefits as accurately as possible, will file my insurance for me. However, changes and benefits which may be unique to my policy can change at any moment and that will result in either a credit or a balance on my account. I am aware that I am fully responsible for this amount.
- * Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
- * If sent to collections, I agree to pay all related fees and court costs.
- * I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
- * I will pay a fee for appointments broken without 24 hours' notice. **The broken appointment fee is \$40.00.**
- * Treatment plans may change, and I will be responsible for the work actually done.

Signature _____ Date _____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Signature _____ Date _____



Happy Children Pediatric Dentistry

Photography Release for Minor Child or Children

I hereby authorize Happy Children, Pediatric Dentistry PC, hereafter referred to as “Company,” to publish photographs taken on _____ of myself and/or the minor child or children listed below, and our names and likenesses, for use in the Happy Children, Pediatric Dentistry PC’s print, online and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless Happy Children, Pediatric Dentistry PC from any reasonable expectation of privacy or confidentiality for myself and for the minor child and children listed below associated with the images specified above. Further, I attest that I am the parent or legal guardian of the child or children listed below and that I have full authority to consent and authorize Happy Children, Pediatric Dentistry PC to use their likenesses and names.

I further acknowledge that participation is voluntary and that neither I, the minor child, or minor children will receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Happy Children, Pediatric Dentistry PC, its contractors, its employees and any third parties involved in the creation or publication of Company publications, from liability for any claims by me or any third party in connection with my participation or the participation of the minor children listed below.

Authorization: _____

Printed Name: _____

Signature: _____ **Date:** _____

Relationship to Children: _____

Names and Ages of Minor Children:

Name: _____ **Age:** _____

Name: _____ **Age:** _____

Name: _____ **Age:** _____