SPRINGFIELD PEDIATRIC DENTISTRY

Child's Information and Insurance

Child's Name: _____ Nickname: _____
Last First M

Male or Female Birthdate: _____ Age: _____ Social Security #: _____

Address: _____
Street Apt#/Lot# City State Zip Code

Please provide Email and Cellphone number for confirmation of appointments:

Email: _____ Cellphone number: _____

Do you have any siblings that come to this office? What are their names?

_____

Whom can we thank for your referral? _____

Dental Insurance: _____ ID#_____

Mother/Guardian Information:

Name: _____ Phone: _____
Last First Home Cell Work

Address: _____
Street Apt#/Lot# City State Zip Code

Birthdate: _____ Social Security #: _____ Employer: _____

Dental Insurance: _____ Group #: _____ ID#: _____

Father/Guardian Information:

Name: _____ Phone: _____
Last First Home Cell Work

Address: _____
Street Apt#/Lot# City State Zip Code

Birthdate: _____ Social Security #: _____ Employer: _____

Dental Insurance: _____ Group #: _____ ID#: _____

Emergency Contacts or Nearest Relative:

1. _____
Name Cell Phone# Home# Relationship

2. _____
Name Cell Phone# Home# Relationship

3. _____
Name Cell Phone# Home# Relationship

I here by authorize payment to Springfield Pediatric Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and preform such diagnostic, photographic, radiographic and therapeutic procedures as may be necessary for proper dental care. The information given on the following forms to be the best of my knowledge. I grant the right of the dentist to release the information about the dental treatment to the third party payors and/or other health professionals. I understand that the office complies with all HIPPA rules and regulations and I may request a copy of those at anytime.

Parent/Guardian Signature: _____ Date: _____

Dr. Andrea Myers, DDS, MSD
2200 Olympic Street * Springfield, OH 45503 * 937.390.0493

SPRINGFIELD PEDIATRIC DENTISTRY

Health History

Patient Name: _____ Birthdate: _____

Has your child had any history of:

□ Sinus Problems	□Autism	□High Blood Pressure	□Respiratory Disorder
□Brain/Nervous Disorder	□Diabetes	□Rheumatic Fever	□_____ Syndrome
□Thyroid Disease	□Allergies	□Cerebral Palsy	□Excessive Bleeding/Hemophilia
□Hepatitis B or C	□Ulcers	□Heart Murmur	□Psychiatric Care
□Epilepsy/Seizures	□AIDS/HIV	□Heart Problems	□Cancer/Chemotherapy
□Tuberculosis	□ADD/ADHD	□Lung Disease	□ Cold Sores/Fever Blisters
□Kidney/Liver Problems	□Asthma	□Hearing Impairments	

Patient attends or has attended:

□Occupational Therapy □Physical Therapy □Speech Therapy

Has your child ever had an unfavorable reaction to any of the following? If YES, please explain:

□Antibiotics_____ □Latex_____
□Any metals_____ □Food_____
□Local Anesthetic_____ □Nuts_____
□Medications_____ □Other_____

Medical History:

Is the child taking any current medications: _____
_____
Has your child had any serious illness not listed above: _____
Has your child even been hospitalized: _____
Primary care doctor name: _____ Phone#: _____
Date of last medical exam: _____

Dental History:

What is the purpose of your child's dental visit with us today?

□Check up & Cleaning □Exam only □2nd Opinion □Mouth/Tooth pain
□Child's 1st visit to dentist □Trauma/Accident □Other

Date of the last dental visit: _____ Name of previous Dentist: _____

Has your child had any history of:

□Toothaches □Tongue Thrusts □Pacifier use □Lip sucking/biting
□TMJ (jaw pain) □Bleeding Gums □Nail Biting □Clenching/Grinding
□Thumb/Finger Sucking □Sensitive to hot/cold

Has your child ever had an unfavorable experience with any previous dental work before?
_____

Does your child: Brush daily? □Yes □No Floss daily? □Yes □No

Signature of parent/guardian: _____ Date: _____

Relationship to patient: _____

Andrea Myers, DDS, MSD
2200 Olympic Street * Springfield, OH 45503 * 937.390.0493

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HIPPA OMNIBUS RULE
PATIENT ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In reusing we may not be allowed to process your insurance claims.

Date: _____

This undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed dated document shall be effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCTUMENT RELEASE SHOULD I REQUEST TREATMENT OF RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR OR FACILITIES IN THE FUTURE.**

_____ _____
Please PRINT name of PATIENT Please SIGN for Patient/Guardian of Patient

_____ _____
Legal Representative/Guardian Relationship of Legal Representative/Guardian

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Please list any other parties who can have access to your child's health information: (this includes step-parents, grandparents and caretakers who can have access to patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT AND BILLING INFORMATION VIA:

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to my Cell Phone
□ Email Confirmation
□ **Any of the Above**

I AUTHORIZE INFORMATION ABOUT MY CHILD'S HEALTH BE CONVEYED VIA:

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to my Cell Phone
□ Email Confirmation
□ **Any of the Above**

I APPROVE BEING CONTACCTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS OR NEW HEALTH INFORMATION ON BEHALF OF THIS HEALTHCARE FACILITY VIA:

□ Cell Phone Confirmation
□ Home Phone Confirmation
□ Work Phone Confirmation
□ Text Message to my Cell Phone
□ Email Confirmation
□ **Any of the Above**

In signing this HIPPA Patient Acknowledgement Form you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration form these affiliated companies. We, under current HIPPA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Employee, I attempted to obtain the patients (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment □
I could not communicate with the patient □
The patient refused to sign □
The patient was unable to sign because □
Other (please describe) □

_____
Signature of Employee