

New Patient Information Form

Patient Information

Patient Full Name: _____

Patient Birth Date: _____ Patient Gender: _____

Parent #1 Information

Parent Full Name: _____ Parent DOB: _____

Relationship to patient: _____ Cell Phone Number: _____

Home Address: _____

Cell Phone Number: _____ Employer: _____

Parent #2 Information

Parent Full Name: _____ Parent DOB: _____

Relationship to patient: _____ Cell Phone Number: _____

Home Address: _____

Cell Phone Number: _____ Employer: _____

Medical Health Form

Is your child in good health? _____

Date of last physical exam? _____

Is your child now under the care of a physician? YES NO

If so, what condition is being treated? _____

Did your child have trouble at birth or during the early years? YES NO

If YES, please describe: _____

Name of pediatrician or family physician? _____

Address and Phone: _____

Has your child had any serious illness or injury? _____

If so, what was the illness? _____

Was your child delivered by Caesarean Section? _____

Has your child ever been hospitalized or had surgery? YES NO

Reason/Day? _____

Have your child's tonsils or adenoids been removed? YES NO

If YES, when? _____

Medical Conditions

Does your child have any medical conditions? YES NO

Select all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Acid Reflux (GERD) | <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Fainting/Dizziness |
| <input type="checkbox"/> ADD | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Cancer/Chemotherapy | <input type="checkbox"/> Genetic Disorders |
| <input type="checkbox"/> Alcoholism/Chemical Dependency | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Head Injuries |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> COPD | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Dementia | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Dry Mouth | <input type="checkbox"/> Hepatitis C |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Blood Disease/Disorder | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Blood Transfusion | | <input type="checkbox"/> Hip or Joint Replacement |

- History of Alcohol Abuse
- HIV
- HPV
- Immune Disorder
- Insomnia
- Jaundice
- Kidney Dialysis
- Kidney Disease
- Latex Sensitivity
- Low Blood Pressure
- Migraines
- Mitral Valve Prolapse

- Multiple Sclerosis
- Neck and Back Problems
- Osteoporosis
- Pacemaker
- Pre-Med Before Treatment
- Psychiatric Care
- PTSD
- Radiation Treatment
- Respiratory Problems/Disease
- Rheumatic Fever
- Sinus Problems
- Sleep Apnea

- Snoring
- Stomach Ulcers
- Stomach/GI Disorders
- Stroke
- Thyroid Disease/Problems
- TMJ/TMD
- Tobacco/Vape/Di ρ Usage (past or current)
- Tuberculosis
- Tumors or Growths
- Venereal Disease
- Other

Does your child have a physical or mental disability? YES NO

If YES, please explain: _____

Medications

Is your child currently taking any medications? YES NO

If YES, please list all current medications:

Is your child currently taking any Vitamins or Supplements? YES NO

If YES, please list all current Vitamins and/or supplements:

Allergies

Does your child have any allergies? YES NO

If YES, please explain: _____

Dental History Form

What is your primary concern about your child's oral health?

How would you describe your child's oral health?

Is there a family history of cavities?	YES	NO
Does your child have inherited dental characteristics?	YES	NO
Does your child have a history of mouth sores or fever blisters?	YES	NO
Does your child have a history of bleeding gums?	YES	NO
Does your child have a history of bad breath?	YES	NO
Does your child have a history of toothaches?	YES	NO
Does your child have a history or injury to the teeth, mouth or jaw?	YES	NO
Does your child have a history of grinding or clenching their teeth?	YES	NO
Does your child have a history or jaw joint problems (locking/popping)?	YES	NO
Does your child have a history of excessive gagging/choking?	YES	NO
Does your child have a history of a thumb sucking habit?	YES	NO
If YES, is the thumb sucking habit current?	YES	NO
Does your child have a history of a pacifier habit?	YES	NO
If YES, is the pacifier habit current?	YES	NO

Brushing and Flossing

Does someone help your child brush their teeth?	YES	NO	
How often does your child's teeth get brushed? 2x/day	Other: _____		
How often does your child floss their teeth?	Nightly	3-4x/week	Never
What type of toothbrush does your child use?	Manual	Electric	Both
What toothpaste does your child use? Training	Fluoride	Hydroxyapatite	Other

Water and Fluoride

Do you use a water filter at home? YES NO

Please check all sources of fluoride your child receives:

- | | |
|--|--|
| <input type="checkbox"/> Fluoride treatment in the dental office | <input type="checkbox"/> Drinking water |
| <input type="checkbox"/> Fluoride treatment by pediatrician/other practitioner | <input type="checkbox"/> Over-the-counter mouth rinse (e.g., Act, Listerine, etc.) |
| <input type="checkbox"/> Prescription (Drops/Tablets/Vitamins) | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Toothpaste | <input type="checkbox"/> None |

Dietary Habits

Does your child regularly eat 3 meals each day? YES NO

Is your child on a special or restricted diet? YES NO

If YES, please explain: _____

Is your child a "picky eater"? YES NO

Does your child have a diet high in sugars or starches? YES NO

Do you have any concerns regarding your child's weight? YES NO

How frequently does your child have the following:

- | | |
|---|---|
| <input type="checkbox"/> Candy or sweets:
_____ | <input type="checkbox"/> Sugary drinks (Gatorade,
Juice, Soda, etc.):
_____ |
| <input type="checkbox"/> Chewing gum:
_____ | |
| <input type="checkbox"/> Snacks between meals:
_____ | |

Sports and Activities

Does your child participate in any sports or similar activities? YES NO

If YES, please explain: _____

Does your child wear a mouth guard during these activities? YES NO

Previous Dental Treatment

Has your child been examined or treated by another dentist? YES NO

Name of dentist: _____

Were X-rays taken of the teeth or jaws? YES NO

Has your child had orthodontic treatment (braces, spacers, expanders)? YES NO

Has your child ever had a difficult dental experience? YES NO

If YES, please briefly explain: _____

Is there anything else we should know before treating your child? YES NO

Parent/Guardian Signature: _____ Date: _____

Acknowledgment of Receipt of Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

- Without specific written authorization, we are permitted to use and disclose your health care records for treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more providers. Examples of treatment would include crowns, fillings, teeth cleaning services, etc.

Payment means obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your dental plan for your dental services.

- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone, text, email or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected health information when we are required to do so by federal, state, or local law. We may disclose your protected health information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your protected health information if requested by a law enforcement official for any circumstance required by law. We may release your protected health information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye, or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your protected health information when (cont.) (cont.) necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

We may disclose your protected health information if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law.

We may disclose your protected health information to correctional institutions or law enforcement HIPAA officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public.

I acknowledge the 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 as effective as the original. I understand I can request a copy of this at any time.

Patient Full Name: _____ Patient Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

HIPAA Release:

I give my permission for Steel City Pediatric Dentistry to release my confidential protected information, including diagnosis, records, examination and treatment rendered to the above patient, billing, and claims information to the following person(s):

Patient Full Name: _____ Patient Date of Birth: _____

Parent/Guardian Signature: _____ Date: _____

I give my permission to release my child's records to myself (if we ever leave the practice) or to another provider (if my child is referred to that office): YES NO

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request verbally or in writing to Steel City Pediatric Dentistry.

Parent Full Name: _____

If this form is being completed by a person with legal authority to act on an individual's behalf, such as a parent or legal guardian of a minor, please complete the following information:

Parent/Guardian Signature: _____ Date: _____

Patient Photo Release Form

Patient Full Name: _____ Patient Date of Birth: _____

I, hereby authorize this Dental Office, or any of their assignee, to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, and videos will be used as a record of my care and may be used for communication with other healthcare professionals, educational publications (dental journals), and education lectures. The content may also be used for advertising purposes (including website publication, Facebook posts, Instagram, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please Select One Below:

- I agree to my photographs being used in any of the above situations
- I only agree to have my teeth shown without any identifying features.
- I do not agree to have photos taken of my child.

Parent/Guardian Signature: _____ Date: _____

Insurance Information

Check one:

- I have primary dental insurance
- I have primary and secondary dental insurance
- I don't have dental insurance

Are you the responsible party for payment? YES NO

Primary Dental Insurance

Subscriber Name: _____ DOB: _____ SSN: _____

Insurance Company: _____ Member ID: _____

Secondary Dental Insurance (Optional)

Subscriber Name: _____ DOB: _____ SSN: _____

Insurance Company: _____ Member ID: _____

Covered Benefits:

As a courtesy, we will verify and file your claim with your insurance carrier; however, we cannot guarantee payment. *You are responsible for payment of any deductible, co-payment/co-insurance, and any non-covered services as determined by your contract with your insurance carrier.*

Many insurance companies have additional stipulations that may affect your coverage. If your insurance company denies any part of your claim, payment will be expected from you. Verification is only an explanation of benefits based upon information that we received from your insurance carrier. It is not a guarantee of payment. Please contact your insurance carrier directly to confirm your individual benefits.

Co-payments and Co-insurance amounts must be paid at each visit according to your insurance contract. Please plan accordingly.

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

Cancellation Policy:

Your appointment is very important to us, and the appointments we book are reserved specifically for you.

We understand that sometimes schedule adjustments are necessary, kids get sick, and life can be a little unpredictable. Therefore, we respectfully request that you provide us with at least 24 hours' notice for any cancellation. Please understand that when you forget or cancel your appointment without giving us proper notice, we miss the opportunity to fill that appointment time. Because of this, patients on our waiting list may miss a chance to receive treatment that they have been waiting to schedule.

After one late cancellation (less than 24 hours' notice) or a no-show, you will receive a warning.

After a second late cancellation or no-show, a \$25 fee will be charged for a missed hygiene visit, or a \$50 fee will be charged for a missed treatment/ restorative visit, and patients will only be able to be scheduled on a same-day availability basis.

After three late cancellations or no-shows, a \$25 fee will again be charged for a missed hygiene visit, or a \$50 fee will be charged for a missed treatment/ restorative visit, and patients will be dismissed from the practice.

Your child's dental health is very important to us, and we strive to keep our waitlist for treatment and hygiene appointments down with your help.

We thank you for your cooperation and understanding.

Parent/Guardian Signature: _____ Date: _____

Treatment Policy:

In order for Dr. Meyers and the staff at Steel City Pediatric Dentistry to safely and effectively treat my child, only 1 parent may be in the room during treatment/cleaning appointments. All other family members, including siblings, are asked to wait in the waiting room.

If you have multiple children scheduled for treatment on the same day, please understand the patient and only 1 parent may be in the room at that time, and that the other child(ren) will have to wait in the waiting room until it is their turn. This includes if you bring another child(ren) that do not have appointments the day of your child's appointment.

Please plan accordingly for your child(rens) appointment(s).

Parent/Guardian Signature: _____ Date: _____