Lufkin KIDS DENTISTRY

PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name: _____Preferred Name: _____ Date of Birth___/___/____
Street Address: _____City: _____State:____ Zip:_____
Home Phone:_____ Age: _____ Sex: Male Female
School Currently Attending: _____Grade Level: _____
Preferred Pharmacy:_____

PARENT INFORMATION

Parent/Legal Guardian: _____ Relation to patient:_____
Employer:_____ Work #:_____ Mobile #:_____Date of Birth ___/___/____
Parent/Legal Guardian: _____ Relation to patient:_____
Employer:_____ Work #:_____ Mobile #:_____Date of Birth ___/___/____
Guardian's Email: _____
Who has legal custody? _____ Dental Insurance Yes No
Person responsible for payment of account _____ SSN#: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home Phone: _____Work Phone: _____ Mobile: _____

CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Lufkin Kids Dentistry and the staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary by Lufkin Kids Dentistry to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Lufkin Kids Dentistry will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Lufkin Kids Dentistry of any changes in my child's medical status.

Legal Guardian's Signature: _____ **Date:**_____

Doctor Signature: _____ **Date:**_____

Lufkin KiDS DENTISTRY

INSURANCE INFORMATION

If you have dental insurance and would like help in completing a standard ADA claim form to submit for reimbursement from your insurance company, complete the information listed below.

Policy Holder Name_____
First Last Middle Initial Date of Birth

Home Address _____
Street City State Zip

Policy Holder SSN and/or Member ID #_____

Relationship to Patient_____

Employer Name _____

Insurance Company Name _____

Group # (if applicable) _____

Phone Number of Insurance Company _____

Address to Mail Dental Claims To:

_____
Street/P.O. Box

_____
City State Zip Code

1218 Ellis Ave., Lufkin, Tx 75904 936-634-6119

DENTAL INFORMATION

Patient First Name: _____ Last Name: _____Birth Date: _____

	Y	N	
Is/Was your child bottle fed?	☐	☐	If yes, until what age? _____
Is/Was your child breast fed?	☐	☐	If yes, until what age? _____
Does your child like to snack during the day?	☐	☐	If yes, what kind/how often?_____
Does your child drink juices/sweetened drinks?	☐	☐	If yes, what kind/how often?_____
Has your child ever had injuries to his teeth, mouth, head or jaws?	☐	☐	If yes, describe: _____
Does your child brush daily?	☐	☐	
Does an adult assist with the brushing?	☐	☐	
Does your child floss daily?	☐	☐	
Does an adult assist with the flossing?	☐	☐	
Did the mother/caregiver have cavities in the last year?	☐	☐	If yes, describe: _____

Does your child have any of the following mouth habits?

☐ Finger sucking ☐ Pacifier ☐ Lip sucking ☐ Teeth grinding

☐ Thumb sucking ☐ Tongue thrusting ☐ Mouth breather

Does your child receive fluoride in any of the following forms?

☐ Vitamins ☐ Water supply ☐ Tablets/drops Dosage: mg/day ☐ Toothpaste ☐ Rinse/gel

MEDICAL INFORMATION

Child's Pediatrician: _____ Address: _____ Phone: _____

Date of last physical? _____

	Yes	No
Is your child in good health?	☐	☐
Are your child's immunizations up to date?	☐	☐
Is your child being treated for any condition presently?	☐	☐
If so, explain: _____		
Is your child taking any medications or drugs?	☐	☐
If so, explain: _____		
Has your child ever been hospitalized or had surgery?	☐	☐
If so, explain: _____		
Does your child have any allergies or reactions to any medications?	☐	☐
If so, explain: _____		

Does your child have any allergies to the following: ☐ **pollen** ☐ **food / food dyes** ☐ **dust** ☐ **latex** **other** _____

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Chronic Headaches	☐	☐	Hemophilia
☐	☐	Allergies to Medication	☐	☐	Chronic Ear Infections	☐	☐	Hepatitis or Liver Disease
☐	☐	Anemia	☐	☐	Cleft Lip / Palate	☐	☐	Hyperactivity
☐	☐	Asthma/Lung Problems	☐	☐	Convulsions / Seizures	☐	☐	Kidney Disease
☐	☐	Autism	☐	☐	Diabetes	☐	☐	Leukemia
☐	☐	Behavior/Language Problems	☐	☐	Endocrine System	☐	☐	Mental/Emotional Disturbances
☐	☐	Bladder Conditions	☐	☐	Epilepsy	☐	☐	Nutritional Deficiency
☐	☐	Blood Transfusions	☐	☐	Eye Problem	☐	☐	Oral Ulcers
☐	☐	Birth Defects	☐	☐	Excessive Bleeding Problem	☐	☐	Orthopedic Problems
☐	☐	Bone or Joint Problems	☐	☐	Excessive Gagging	☐	☐	Premature Birth
☐	☐	Brain Injury	☐	☐	Fainting or Dizziness	☐	☐	Rheumatic Fever
☐	☐	Bruising Easily/ Abnormal Bleeding	☐	☐	Frequent Infections	☐	☐	Sickle Cell Anemia
☐	☐	Cancer or Malignancies	☐	☐	Growth & Development Problems	☐	☐	Significant Injury
☐	☐	Cerebral Palsy	☐	☐	Hearing/Speech Problems	☐	☐	Syndrome _____
☐	☐	Child Abuse	☐	☐	Heart Problems	☐	☐	Other _____
☐	☐	Chronic Adenoid/Tonsil Infection						

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information that has not been covered:

_____

DDS Initials:

Lufkin KiDS DENTISTRY

FINANCIAL OFFICE POLICY

In consideration for the professional services rendered to me, I agree to pay for these services, at the time of the services are rendered unless financial arrangements are made in advance. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time of service. Our fees reflect our commitment to the quality of care that our patients deserve. If you have insurance, we are happy to assist you in processing your insurance claims to maximize your benefits. **INSURANCE ESTIMATES** will assist you in determining your **APPROXIMATE OUT OF POCKET EXPENSE**. Please note **THAT INSURANCE ESTIMATES ARE NOT A GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY**. We ask you to keep in mind that your insurance policy is a contract between your employer, yourself and the insurance company. We are not part of that agreement.

REGARDLESS OF INSURANCE COVERAGE, ALL FEES AND ACCOUNT BALANCES ARE THE PATIENTS RESPONSIBILITY.

As a patient of Lufkin Kids Dentistry I understand my financial responsibility and also give consent to use this signature on all insurance claims, to release records, including x-rays for insurance purposes only. I also give you permission to contact me by phone or e-mail concerning any matters related to my treatment or account. I give consent for my dental treatment as deemed necessary.

Thank you for choosing Lufkin Kids Dentistry.

HIPAA

ACKNOWLEDGEMENT OF RECEIPT / REVIEW OF NOTICE OF PRIVACY PRACTICES
I have received and reviewed a copy of this office's Notice of Privacy Practices.

**IT IS YOUR LEGAL OPTION TO NOT SIGN THIS ACKNOWLEDGEMENT; HOWEVER, OUR POLICY STATES THAT IF WE DO NOT HAVE THIS ACKNOWLEDGEMENT FROM YOU, WILL NOT BE ABLE TO PROVIDE YOU WITH OUR SERVICES.

_____ _____ _____
Signature of patient, parent or guardian Date Relationship to Patient

- IF YOU WOULD LIKE A COPY OF THIS PAGE, PLEASE NOTIFY THE FRONT DESK.

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
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other _____

If other, was marked please specify: _____

Name of office personnel:_____