Child Health/Dental History Form

ADA American Dental Association®
America's leading advocate for oral health

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ❑ F ❑	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

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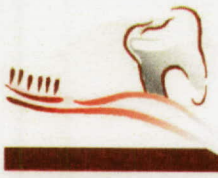

PETER A. WERT, DDS
JAYMI SIMPSON-WERT, DDS
WOODLANDS FAMILY and COSMETIC DENTISTRY

Patient Name_____ Birthdate_____ SS#/ID#_____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate_____ SS#/ID#_____

Address_____
Street City State Zip

Phone (___)_____ Business Phone (___)_____

Person Employed by _____ Occupation_____

Military Pay Grade (if Applicable)_____ Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

ADDITIONAL INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient_____ Birthdate_____ SS#/ID#_____

Address_____
Street City State Zip

Phone (___)_____ Business Phone (___)_____

Person Employed by _____ Occupation_____

Military Pay Grade (if Applicable)_____ Insurance Company_____

Contract #_____ Group #_____ Subscriber #_____

AUTHORIZATION AND RELEASE

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the doctor to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature of patient or parent if minor:_____ Date:_____

WERT-SIMPSON DENTAL, P.C.
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Release of Protected Information to Family Members and Person Involved in Patient's Care or Payment

With your permission, Wert-Simpson Dental may release your protected health information to a family member or another person involved in your care or payment for your health care. For example, Wert-Simpson Dental may tell a family member when your procedure is scheduled; discuss your care or payment involved. By completing the top portion of this form, you are authorizing Wert-Simpson Dental to release this information to these individuals.

However, *you are not authorizing Wert-Simpson Dental to provide extensive information about your medical history or copies of information from your medical record.* If you wish to have this information disclosed, *you must complete a separate HIPAA authorization form.*

Please be aware that Wert-Simpson Dental may use its professional judgment in determining the amount of information it may disclose to any person besides yourself, and in refusing to disclose your health information.

Please identify the person or persons who are involved in your care or the payment of your care that you authorize to receive your protected health information. This may include your spouse, parents, siblings, children, close friend or guardian. Please list below:

Name	Relationship

Authorization to Leave Voice Messages

Please circle one:

Yes Wert-Simpson Dental **may** leave a message on my answering machine/voice mail regarding my
No care, appointment, or financial obligations.
Preferred contact phone number: _____ _____

Yes Wert-Simpson Dental **may** leave a message via text message on my phone regarding my
No appointments. _____

I understand that if I change my mind about any of the information in this form, I must contact Wert-Simpson Dental to revoke this form in its entirety or to complete a new form.

_____ _____
Patient and/or Legal Guardian Signature Today's Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Print Name

_____ _____
Date Witness

OFFICE USE ONLY

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgment
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please specify) _____

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PAYMENT POLICY

- Payment is expected at the time service is rendered. We will accept cash, personal checks, debit cards, and the following credit cards: Visa, MasterCard, and Discover.
- Non-insured patients are expected to make payment in full on the day service is rendered.
- We offer financing through Care Credit and Chase Health Advance with approved credit.
- Patients with dental insurance are expected to pay, on the day of service, that portion of the total fee not covered by their insurance. This "patient portion" is only an **estimated** dollar amount.
- A 3% finance charge will be added to all accounts over 60 days past due.

As a **courtesy**, our office will file your claim with your insurance company, and initiate correspondence with the purpose of getting you the maximum coverage your insurance will allow: however, if we do not receive payment from your insurance company within 60 days, the payment becomes your responsibility.

APPOINTMENTS

Your scheduled appointment time has been reserved specifically for you. We request 24 hours notice if you need to cancel your appointment. Giving us this notice will allow us to offer your reserved appointment to another patient or a patient with emergency needs. We are aware that unforeseen events sometimes require missing an appointment without advance notice. Please advise our office if this has occurred. Repeated appointments missed without giving our office at least a 24 hour notice, will result in a **$50** fee. This fee allows our office to be compensated for the set-up cost.

I have read the above policies and agree to abide by them.

Signed:_____ Date:_____

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain