

Patient Demographics, Medical and Dental History

Patient Name: _____ DOB: _____ Sex: Male Female
 Parents Names: _____ Primary Insurance Carrier: Mother Father
 Primary Contact Tel: _____ Work Tel: _____ Mobile: _____
 Email Address: _____ School/Preschool: _____
 Home Address: _____
 Referral Source: _____
 Primary Insurance Carrier: DOB: _____ SSN: _____ Employer: _____
 Insurance Company: _____ Group No: _____ Insurance Phone: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dental care that he/she receives. Thank you for answering the following questions.

Primary Physician Name: _____ Telephone: _____
 Is your child under the care of a specialist for any medical condition? Yes No
 If, yes: Specialist Physician Name: _____ Telephone: _____

Does your child have or has had any of the following medical conditions?

AIDS/HIV	Yes	No	Anemia	Yes	No
Artificial Joint	Yes	No	Asthma	Yes	No
Blood Disease	Yes	No	Breathing Problem	Yes	No
Cancer	Yes	No	Chemotherapy	Yes	No
Cold Sores	Yes	No	Diabetes	Yes	No
Emphysema	Yes	No	Epilepsy/Seizures	Yes	No
Excessive Bleeding	Yes	No	Fainting/Dizziness	Yes	No
Frequent Headaches	Yes	No	Heart Murmur	Yes	No
Hemophilia	Yes	No	Hepatitis	Yes	No
Kidney Problems	Yes	No	Liver Disease	Yes	No
Lung Disease	Yes	No	Mitral Valve Prolapse	Yes	No
Psychiatric Care	Yes	No	Renal Dialysis	Yes	No
Rheumatic Fever	Yes	No	Rickets	Yes	No
Scarlet Fever	Yes	No	Seasonal Allergies	Yes	No
Sickle Cell Disease	Yes	No	Spina Bifida	Yes	No
Stomach Disease	Yes	No	Thyroid Disease	Yes	No
Tonsillitis	Yes	No	Tumors or Growths	Yes	No
Ulcers	Yes	No	Jaundice	Yes	No

Has your child ever had any serious illness not listed above? Yes No
 If yes, explain _____

Does your child take any medications either orally or inhaled? If yes, please list names and doses. _____	Yes	No
Has your child ever had a surgery or been in the hospital? If yes, when and what for? _____	Yes	No
Allergies to medications, latex, metals, and/or foods? If yes, please list. _____	Yes	No
Is your child following the recommended schedule of vaccinations?	Yes	No
Does your child have a syndrome or medical disorder? If yes, please explain. _____	Yes	No
Reason for your child's last dental visit. _____		
Who was your child's previous dentist? _____		
Date of your child's last dental x-rays. _____		
Has your child had any complications following dental treatment? If yes, explain. _____	Yes	No
Has your child had any injury to the teeth, jaws, or face? If yes, explain. _____	Yes	No
Are you unhappy with the appearance of your child's teeth? If yes, explain. _____	Yes	No
Do your child's gums bleed with brushing? If yes, where? _____	Yes	No
Are any of your child's teeth sensitive to hot, cold or eating? If yes, where? _____	Yes	No
Does your child complain of a toothache? If yes, explain. _____	Yes	No
Does your child experience pain or clicking in the jaw joints? If yes, explain. _____	Yes	No
Are there any growths in your child's mouth? If yes, where? _____	Yes	No
Does your child suck fingers, thumb or pacifier?	Yes	No
Do you use toothpaste that contains fluoride?	Yes	No
Do you use any form of supplemental fluoride rinse or tablets?	Yes	No
Do you think your child will cooperate for dental treatment?	Yes	No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental staff of any changes in medical status.

Parent/Guardian Signature: _____ Date: _____

CLARK PEDIATRIC DENTISTRY PRACTICE POLICIES AND CONSENT FOR TREATMENT

Patient Name: _____ DOB: _____

Welcome to Clark Pediatric Dentistry! Our goal is to provide your child the highest quality dental care; we are confident that is your goal as well. Please take the necessary time to review the following policies that will guide us to our mutual goal. After reviewing these policies, please feel free to ask us any questions.

PATIENT ACCOUNTS

- **FILING INSURANCE:** As a courtesy to our patients, Clark Pediatric Dentistry will file any patient's primary insurance. To file your insurance, we require the **social security number** of the policy holder and responsible party (these may not always be the same person). Allowing Clark Pediatric Dentistry to handle your insurance will free you from the time consuming and complicated insurance claims process. During the claim filing process, we work with **insurance estimates**; therefore, at claim resolution there may be account "settling."
- **PAYMENTS:** If we file your insurance, **Clark Pediatric Dentistry will extend you credit for your estimated insurance benefits and require that you pay the remaining balance on the date of service.** By extending you credit for the estimated insurance and waiting for insurance reimbursement, Clark Pediatric Dentistry allows you to keep more money in your pocket for routine expenses. We accept Master Card, Visa, Checks, and Cash.

PATIENT APPOINTMENTS

- **EXCELLENT PATIENT CARE:** Clark Pediatric Dentistry will make every attempt to reserve the sufficient time necessary to deliver the highest quality dental care possible to your child. Please arrive on time to your appointments, so that your child will be able to take full advantage of your reserved time. **If you arrive over 15 minutes late for your appointment, we may reschedule the appointment to allow sufficient time for excellent patient care.** Consistent or excessive lateness may result in dismissal from the practice.
- **"DIS-APPOINTMENTS":** Clark Pediatric Dentistry will be "disappointed" if you are unable to keep a scheduled appointment. Please notify our office and reschedule as soon as possible. **If you fail to notify our office within 24 hours prior to the scheduled appointment, a twenty-five dollar fee will be charged.** Consistent or excessive "dis-appointments" may result in dismissal from the practice.

PARENTAL EXPECTATIONS DURING DENTAL CARE

- **PARENTAL ATTENDANCE:** Clark Pediatric Dentistry believes communication is imperative to ensure excellent patient care. **For this reason, a parent, or legal guardian, must attend all dental appointments, and remain at Clark Pediatric Dentistry during that appointment.**
- **PARENTAL INVOLVEMENT:** It has been our experience that most children, ages three and over, cooperate better without a parent in the clinical area. Our preference, at Clark Pediatric Dentistry, is that you allow our experienced staff to guide your child through the dental experience. Some separation anxiety may be normal; we will carefully allay your child's fears and ask for your assistance only if needed. Some parents prefer to accompany their child in the clinical area and you are more than welcome to do this. If this is your preference, we ask that you inform our staff and make provisions prior to the appointment. To ensure the safety and privacy of all patients, other children who are not being treated should remain in the reception room with a supervising adult. Please remember that any clinical observations and conversations must be kept private in accordance with the health information privacy rules.

My signature below means that I have read and understand the above policies, I have read the "HIPPA Notices of Privacy Practices" provided to me, and that I consent to dental treatment as prescribed by Jason D. Clark DDS of Clark Pediatric Dentistry. I am signing below as the responsible party.

Responsible Party Name: _____ DOB: _____

Responsible Party Signature: _____ SSN: _____