

PATIENT INFORMATION- WELCOME!

Date _____

Patient's name _____
Last First Middle

Nickname _____

Address _____
Street City Zip

Home Phone _____ Birth date _____ Social Security # _____

Hobbies/Interests _____

Siblings/Ages _____

Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle

Social Security # _____ Birth date _____ Relationship to Patient _____

Employer _____ Occupation _____

Residence _____
Street City Zip

Mailing Address _____
Street City Zip

Home phone _____ Work phone _____

Cell/other phone _____ Email address _____

Spouse's Name _____ Relationship to Patient _____

Social Security # _____ Birth date _____ Phone _____

Employer _____ Occupation _____

PRIMARY DENTAL INSURANCE INFORMATION

Insured's Name _____ Insured's Social Security # _____

Insurance Company: _____ Group No. _____ Local No. _____

Insurance Co. Address: _____ Phone No. _____

EMERGENCY INFORMATION

Name/Relationship to child _____

Address _____
Street City Zip

Phone(s) _____

Parent's Signature _____

Updates (date & initial) _____

MEDICAL HISTORY

Physician _____ Date of Last Visit _____
Address _____ Phone _____

Please circle Yes or No (If Yes, please fill in details):

Yes No Is your child taking any medication? _____

Yes No Does your child have a history of a major illness? _____

Yes No Has your child had any operations/hospital stays? _____

Yes No Is your child allergic to any medication? _____

Yes No Is your child allergic to any foods? _____

Yes No Is your child biologically related to you?*

**We value the integrity of your family and understand this question may be a sensitive one for some families; please leave blank if you'd prefer to address this verbally and/or privately with your dentist.*

We welcome patients with special needs and complex medical conditions.

Please circle any of the medical conditions below that apply to your child:

ADD/ADHD	Cancer	Heart Problems	Radiation/Chemotherapy
Anemia	Diabetes	Hepatitis/Liver problems	Rheumatic Fever
Arthritis	Epilepsy	HIV/AIDS	Special Needs
Asthma or Hayfever	GI Disorders	Kidney problems	Tuberculosis
Bleeding Problems	Hearing Impairment	Nervous Disorders	
Bone Disorders	Heart Murmur	Pneumonia	

Are there any medical conditions not included above that you feel we should be aware of? _____

DENTAL HISTORY

Previous Dentist _____ Date of last visit _____

Yes No Do you have any special concerns about your child's teeth? _____

Yes No Does your child brush his/her teeth daily? _____

Yes No Is your child presently in any dental pain? _____

Yes No Has your child ever experienced any unfavorable reaction to dentistry? _____

Yes No Has your child ever lost or chipped any teeth? _____

Yes No Have there ever been any injuries to face, mouth, or teeth? _____

Yes No Does your child have any type of thumb or other oral habit? _____

Yes No Does your child snore or breathe through their mouth? _____

Yes No Does your child grind his/her teeth? _____

Yes No Are you aware that some appointments will be during school/work hours? _____

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA. You will receive a copy of the "Notice of Privacy Practices" when you arrive at the office.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform Pine Dental Care of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. **The Parent or Guardian who accompanies the child is responsible for payment at the time of service.**

Signature of Parent or Guardian: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

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

Please Print Name

Signature

Date

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

- Communications barriers prohibited obtaining the acknowledgement

- An emergency situation prevented us from obtaining acknowledgement

- Other (Please Specify)-
