

Patient Information

Patient Name: _____ Date: _____
Last, First MI
Nickname: _____ Gender: _____ Birth Date: _____
Phone (Home): _____
Address: _____
Street Apartment #
City State Zip Code

- Patient's Siblings and their ages: _____
- Does your child speak English? Yes No
What language does your child speak at home? _____
- Who can we thank for referring you to our office? _____

Health Information

Has this patient ever had any of the following? Please circle those that apply:

ADD	Chicken Pox	Hepatitis	Rheumatic Fever
Allergy-Codeine	Diabetes	High Blood Pressure	Stomach Problems
Allergy-Penicillin	Drug Dependency	HIV	Tuberculosis
Allergies: _____	Epilepsy / Seizures	Kidney Disease	Tumors
_____	Excessive Bleeding	Liver Disease	Ulcers
Anemia	Fainting	Measles/Mumps	OTHER: Please List Below
Arthritis	Head Injuries	Mental Disorders	_____
Asthma	Heart Disease	Nervous Disorders	_____
Blood Disease	Heart Murmur	Radiation Treatment	_____
Cancer	Hemophilia	Respiratory Disease	NONE

- Is your child currently under the care of a physician? Yes No
If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Does your child require pre-medication for heart disease or a heart murmur prior to dental visits? Yes No
- Is your child taking any prescription medications, over-the-counter medications, or herbal remedies? Yes No
If yes, please list: _____
- Does your child have any health problems that need further clarification? Yes No
If yes, please explain: _____
- Has your child ever been admitted to a hospital overnight or needed emergency care for something other than routine care? Yes No
If yes, please explain: _____
- Does your child have any behavioral issues that we need to be aware of? Yes No
If yes, please explain: _____
- Has a physician/dentist warned against giving your child any specific drug or medication? Yes No
Which ones? _____
- Does your child bruise easily? Yes No
- Has your child ever bled excessively after a cut or injury? Yes No
- Was a physician consulted? Yes No
- Has your child had frequent nose bleeds? Yes No Has your child ever had a transfusion? Yes No
- Has your child ever been given penicillin? Yes No
- Has a physician ever suggested taking medication before a dental visit? Yes No

Previous Dentist Information

Name: _____ City: _____ State: _____

Phone: _____

• Date of Last Dental Visit: _____
 Reason for this visit: _____
 How well was treatment received? _____

• Have there ever been any complications following dental treatment? Yes No
 If yes, please explain: _____

• Has your child ever had local anesthesia ("Novocain")? Yes No Reactions? _____

• Does your child have any habits that might affect the teeth or mouth (Thumb, finger or pacifier sucking, tongue habit, biting or sucking lips, or breathing through the mouth)? Yes No If yes, explain: _____

• At what age did your child give up breastfeeding/ the bottle? _____

• How many times per day are your child's teeth brushed? _____

• Has your child had fluoride of any sort?
 Fluoride in water? Yes No How long? _____ Fluoride Supplements? Yes No How long? _____

• Have dental x-rays been taken on your child? Yes No Date of last x-rays: _____

Parent Information

Parent Name: Hewitt, Alastair Relationship to patient: _____
 Male Female Married Single Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Occupation: _____

Address: _____
(work) Street Apartment #
City State Zip Code

E-mail: _____

Is this Parent Responsible for the Account? Yes No

Parent Information

Parent Name: _____ Relationship to patient: _____
 Male Female Married Single Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Occupation: _____

Address: _____
(work) Street Apartment #
City State Zip Code

Is this Parent Responsible for the Account? Yes No

Would you like to receive periodic emails regarding advances in our office, pediatric dentistry, and appointment reminders? Yes No

E-mail: _____

Insurance Information

Primary

Name of Subscriber: _____
Last First MI
Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: Self Spouse Child Other _____

Insurance Plan Name and Address: Delta Dental Plan

Secondary

Name of Subscriber: _____ Is subscriber a patient? Yes No
Last First MI
Subscriber's Birth Date: _____ ID #: _____ Group #: _____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: Self Spouse Child Other _____

Subscriber Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services, performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Consent To Disclose General Health Information

By my signature below, I hereby authorize the office of Michael R. Coppe, D.M.D. to disclose my dental/medical information so that any doctor in the practice may treat me, seek payment from third parties for such treatment, and generally carry on dental care operations. I also authorize the office to disclose my medical/dental information to insurers and providers outside of the office when necessary so that these providers may treat me; seek payment for that treatment, and for the purpose of their health care operations.

My Highly Confidential Information

I understand that my medical/dental record currently contains or may contain in the future highly confidential information. By my signature below, I specifically consent to the disclosure of such information as part of my medical/dental record to insurers and providers outside the office for the purpose of obtaining treatment for me, payment for the treatment provided to me, and so that these entities can carry out their health care operations.

I have read the above conditions of treatment and payment and agree to their content. To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there are ever any changes to this health information, I will inform the doctors at the next appointment without fail.

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

Signature of guarantor of payment/responsible party Date: _____ Relationship to Patient: _____