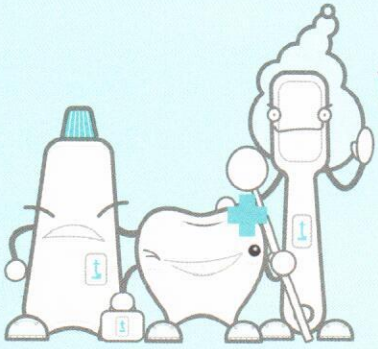

welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining you and your child's dental health.

1. PATIENT INFORMATION

Date _____ SS/HIC/Patient ID# _____

Patient Name _____

Address _____

City _____ State _____ Zip _____

Sex : M F Age _____ Birthdate _____ SS# _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ Email _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ Email _____

2. DENTAL HISTORY

Place a mark on "YES" or "NO" to indicate if you have had any of the following;

Reason for today's visit

_____

Former Dentist

_____

City/State

_____

Date of last dental visit

_____

Date of last dental X-rays

_____

	YES	NO		YES	NO
Bad breath	☐	☐	Lip or cheek biting	☐	☐
Bleeding gums	☐	☐	Loose teeth or broken fillings	☐	☐
Blisters on lips or mouth	☐	☐	Mouth breathing	☐	☐
Burning sensation on tongue	☐	☐	Mouth pain, brushing	☐	☐
Chew on one side of mouth	☐	☐	Orthodontic treatment	☐	☐
Cigarette, pipe or cigar smoking	☐	☐	Pain around ear	☐	☐
Clicking or popping jaw	☐	☐	Periodontal treatment	☐	☐
Dry mouth	☐	☐	Sensitivity to cold	☐	☐
Fingernail biting	☐	☐	Sensitivity to heat	☐	☐
Food collection between the teeth	☐	☐	Sensitivity to sweets	☐	☐
Foreign objects	☐	☐	Sensitivity when biting	☐	☐
Grinding teeth	☐	☐	Sores or growths in your mouth	☐	☐
Gums swollen or tender	☐	☐	How often do you floss? _____		
Jaw pain or tiredness	☐	☐	How often do you brush? _____		

3. HEALTH HISTORY

Place a mark on "YES" or "NO" to indicate if you have had any of the following;

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). YES ☐ NO ☐

	YES	NO		YES	NO		YES	NO
AIDS/HIV	☐	☐	Epilepsy	☐	☐	Radiation Treatment	☐	☐
Anemia	☐	☐	Fainting or dizziness	☐	☐	Respiratory Disease	☐	☐
Arthritis, Rheumatism	☐	☐	Glaucoma	☐	☐	Rheumatic / Scarlet Fever	☐	☐
Artificial Heart Valves	☐	☐	Headaches	☐	☐	Shortness of Breath	☐	☐
Artificial Joints	☐	☐	Heart Murmur	☐	☐	Sinus Trouble	☐	☐
Asthma	☐	☐	Heart Problems	☐	☐	Skin Rash	☐	☐
Back Problems	☐	☐	Hepatitis Type	☐	☐	Special Diet	☐	☐
Bleeding abnormally w/ extractions or surgery	☐	☐	Herpes	☐	☐	Stroke	☐	☐
Blood Disease	☐	☐	High Blood Pressure	☐	☐	Swollen Feet or Ankles	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Swollen Neck Glands	☐	☐
Chemical Dependency	☐	☐	Jaw Pain	☐	☐	Thyroid Problems	☐	☐
Chemotherapy	☐	☐	Kidney Disease	☐	☐	Tonsillitis	☐	☐
Circulatory Problems	☐	☐	Liver Disease	☐	☐	Tuberculosis	☐	☐
Congenital Heart Lesions	☐	☐	Low Blood Pressure	☐	☐	Tumor or growth on head or neck	☐	☐
Cortisone Treatments	☐	☐	Mitral Valve Prolapse	☐	☐	Ulcer	☐	☐
Cough, persistent or bloody	☐	☐	Nervous Problems	☐	☐	Venereal Disease	☐	☐
Diabetes	☐	☐	Pacemaker	☐	☐	Weight Loss, unexplained	☐	☐
Emphysema	☐	☐	Psychiatric Care	☐	☐			

4. AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign
Name of Insurance Company(ies)

directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This content will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____ day of _____, 2015

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

KIDS CARE DENTAL

Especialistas Pediatricos Dentales