CHILD NEW PATIENT FORM

PATIENT INFORMATION

PATIENT NAME _____DATE OF BIRTH _____

PARENT(S)/GUARDIAN NAME_____

ADDRESS _____CITY _____ STATE _____ ZIP _____

HOME PHONE _____ EMERGENCY CONTACT _____ PHONE _____

PERSON RESPONSIBLE FOR ACCOUNT ❑FATHER ❑MOTHER ❑GUARDIAN ❑ OTHER _____
E-MAIL: _____

INSURANCE INFORMATION

PRIMARY INSURED _____ HM PHONE _____ WK PHONE_____

ADDRESS _____

EMPLOYER _____ SS# _____ BIRTHDATE _____

PLAN NAME _____ GROUP # _____ POLICY # _____

DENTAL HISTORY

DATE OF LAST VISIT TO DENTIST _____ PREVIOUS DENTIST _____

HAS CHILD COMPLAINED OF ANY DENTAL PROBLEMS? NO YES ANY INJURIES TO MOUTH OR TEETH? NO YES

HOW OFTEN DOES CHILD: BRUSH?_____ FLOSS? _____

DOES CHILD USE FLUORIDE DROPS OR TABLETS? NO YES ANY UNHAPPY DENTAL EXPERIENCES? NO YES

MEDICAL HISTORY

CHILD'S PHYSICIAN _____ PHONE _____

TAKING ANY MEDICATIONS? _____

ANY ALLERGIES TO MEDICATIONS?_____

EVER HAD A SURGERY OR HOSPITALIZATION? _____

ANY PROBLEMS WITH THE FOLLOWING:

❑ HEART PROBLEMS	❑ RHEUMATIC FEVER	❑ ANEMIA	❑ ASTHMA	❑ CANCER
❑ KIDNEY DISEASE	❑ EPILEPSY/SEIZURES	❑ HEPITITIS	❑ DIABETES	❑ HIV/AIDS
❑ LIVER PROBLEMS	❑ TUBERCULOSIS	❑ OTHER _____		

AUTHORIZATION

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO ELLIS DENTISTRY OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT. I HEREBY AUTHORIZE ELLIS DENTISTRY TO ADMINISTER SUCH MEDICATIONS AND PERFORM SUCH DIAGNOSTIC, PHOTOGRAPHIC AND THERAPEUTIC PROCEDURES AS MAY BE NECESSARY FOR PROPER DENTAL CARE. THE INFORMATION ON THIS PAGE AND THE DENTAL/MEDICAL HISTORIES ARE CORRECT TO THE BEST OF MY KNOWLEDGE.
PARENT/GUARDIAN SIGNATURE _____ DATE_____

DOCTOR'S SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Ellis Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Ellis Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number :_____ Date: _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided: _____**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	