Today's Date: _____

Welcome!

Patient Information

_____ _____ _____
Child's Legal Name | Preferred Name | Gender Preference

_____ _____ _____
Child's Birthdate | School | Child's Home Street Address

_____ _____ _____ _____
Child's Primary Phone # | City | State | Zip

Parent/Guardian Information

_____ _____
Name of Person Completing Paperwork | Relationship to Child

Who has legal custody of the child? _____

_____	_____
Parent/Guardian Name	Parent/Guardian Name
_____	_____
Relationship to Child	Relationship to Child
_____ _____	_____ _____
Primary Phone # Secondary Phone #	Primary Phone # Secondary Phone #
_____ _____	_____ _____
Other Phone # Occupation	Other Phone # Occupation
_____	_____
Employer	Employer
_____	_____
Email	Email
_____ _____	_____ _____
S.S. # Birthdate	S.S. # Birthdate
☐Check here if address same as child's OR indicate below	☐Check here if address same as child's OR indicate below
Address:_____	Address:_____
_____	_____

Parent's/Guardian's Martial Status: Single◯ Married◯ Divorced◯ Separated◯ Widowed◯ Domestic Partners◯

Family Information

Was your child adopted? Yes◯ No◯

Other family members seen here: _____

Whom may we thank for referring you: _____

Primary Insurance	Secondary Insurance
_____	_____
Subscriber's Name	Subscriber's Name
_____ _____	_____ _____
Insurance Co. State	Insurance Co. State
_____ _____	_____ _____
Subscriber ID Group #	Subscriber ID Group #
_____ _____	_____ _____
Subscriber Date of Birth Insurance Co. Phone #	Subscriber Date of Birth Insurance Co. Phone #

Child's Name: _____ **Reason for today's visit:** _____

Dental History

Is this your child's first visit to a dentist: Yes___ No___
If no, who was the previous dentist?

_____

Date of last dental visit: _____
Were any x-rays taken when your child previously visited the dentist? Yes___ No___
Has your child ever had a problem associated with dental treatment? Yes___ No___
Has your child ever had any pain in mouth or jaw? Yes___ No___
Has your child ever had any trauma to their head or neck? Yes___ No___
Does your child brush their teeth daily? Yes___ No___
Do you assist in brushing? Yes___ No___
Does your child floss daily? Yes___ No___
Do you assist in flossing? Yes___ No___

Diet History

Does/Did your child:
Bottle feed? Yes___ No___ Age when stopped _____
Breast feed? Yes___ No___ Age when stopped _____
Snack more than twice a day? Yes___ No___
What does your child drink with meals? _____

_____

What does your child drink between meals? _____

_____

Does your child has any dietary restrictions? Yes___ No___
Does your child have an eating disorder? Yes___ No___
Does your child take fluoride supplements? Yes___ No___
WATER: City _____ Well _____ Bottled _____

Medical History

Check any of the following which your child has had or presently has**:**

☐ADD/ADHD	☐Diabetes	☐Mental Illness
☐Allergies	☐Down Syndrome	☐Pregnancy
☐Arthritis	☐Emotional Impairment	☐Premature Birth
☐Artificial Joint/Valve	☐Hearing Impairment	☐Physical Impairment
☐Asthma	☐Hepatitis/Liver Disorder	☐Seizure Disorder
☐Autism	☐High Blood Pressure	☐Sickle Cell Anemia/Trait
☐Bleeding Disorder	☐HIV	☐Speech Impairment
☐Cancer	☐Hospitalization	☐Surgery
☐Cerebral Palsy	☐Kidney Disorder	☐Tuberculosis
☐Congenital Heart Defect	☐Latex Sensitivity	☐Vision Impairment

☐ Check here if NONE apply

Please explain any of the above checked conditions or any serious medical conditions not listed: _____

_____

Please list all medications your child is currently taking: _____

_____

Please list all the medications your child has an allergic reaction to: _____

_____

Child's Physician: _____ Physician's Phone #: _____

Last Visit: _____

I understand that the above information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes to my child's medical status.

_____ _____

Signature of Parent or Guardian **Date**

Updated March 2021

Financial Agreement
Ann Arbor Pediatric Dentistry

Payment Responsibilities:

- Payment is due at the time of service, including estimated insurance deductibles and copayments.
- We accept cash, personal checks, VISA, MC, Discover and American Express.
- We charge a $26.00 fee for unpaid checks returned from the bank.
- We charge a **$35.00 fee** for missed appointments and appointments cancelled with ***less than 1 business days' notice.***
- Divorce Situations: The adult who brings the child to their appointment is responsible for any payment due at the time of service. Please inform us, no later than the date of service, of any CHILD CUSTODY arrangements that may affect billing or insurance claims submission.

Insurance Policy:

Our dentists recommend preventative services and treatment based on what we believe is best for your child. We do NOT and CANNOT recommend treatment based on your insurance coverage. If you have any questions regarding the proposed treatment or cost, please ask and we will provide a complete explanation.

As a service to our patients, we offer insurance claim submission. Please understand that we can only **ESTIMATE** your insurance coverage. By submitting your insurance claims directly for you, we handle one step in the process. Deductibles or copayments are to be paid at the time of service. Please be aware that dental insurance companies rarely cover 100% of dental fees. We are committed to helping you achieve the maximum benefit to which you are entitled.

I hereby authorize and direct payment of dental benefits, otherwise payable to me, directly to the billing dentist.

_____ _____

Patient Name (please print) Date

_____ _____

Parent or Legal Guardian Name (please print) Parent or Legal Guardian Signature

Affordability: If you have a true financial hardship, which will prevent your child from receiving the recommended care, please let us know. We can discuss your payment plan options.

Authorization for Use and Disclosure of Health Information

Ann Arbor Pediatric Dentistry

Section A:

I hereby authorize the use and disclosure of my and my child's protected health information, which is deemed necessary in connection with my child's treatment, as described in the Notice of Privacy Practices.

_____	_____
Patient Name (please print)	Date
_____	_____
Parent or Legal Guardian Name (please print)	Parent or Legal Guardian Signature

Section B:

I hereby authorize the following person(s) to receive my child's protected health information.

Please list any person(s) that you consent to have your child's information disclosed to, either verbally or in writing (Ex. Grandparents, Aunt/Uncle, or Nanny whom may be bringing child to appointments). This information can be changed at anytime by giving us written notice of your requested changes.

_____	_____
_____	_____
_____	_____
_____	_____
Name (please print)	Relationship to Child (please print)
_____	_____
Patient Name (please print)	Date
_____	_____
Parent or Legal Guardian (please print)	Parent or Legal Guardian Signature

For Office Use Only

We attempted to obtain written consent for use and disclosure of health information according to the Notice of Privacy Practices, but consent could not be obtained because:

- ☐ Parent or Legal Guardian refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

_____

_____	_____	_____
Office Personnel (please print)	Office Personnel Signature	Date

Acknowledgement of Receipt of Notice of Privacy Practices
Ann Arbor Pediatric Dentistry

I acknowledge that today I was offered a copy of this office's Notice of Privacy Practices.

_____ _____
Patient Name (please print) Date

_____ _____
Parent or Legal Guardian Name (please print) Parent or Legal Guardian Signature

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:

- ☐ Parent or Legal Guardian refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

_____

_____ _____ _____
Office Personnel (please print) Office Personnel Signature Date