KERRVILLE
PEDIATRIC DENTISTRY

PATIENT HISTORY

Tell us about your child:

Patient's Name: _____ Age: _____ DOB: _____Social #: _____-_____-_____
Nickname: _____ Hobbies: _____ ☐ Male ☐ Female
Physical Address: _____
Physical Address: _____
Home phone: (_____) _____-_____ School: _____

Father's Information: ☐ Married ☐ Single ☐ Guardian ☐ Step-father ☐ Foster parent

Name: _____ DOB: _____Social #: _____-_____-_____
Employer: _____ Work phone: (_____) _____-_____
Driver's license: _____ Expires: _____
Home phone: (_____) _____-_____ Cell phone: (_____) _____-_____

Mother's Information: ☐ Married ☐ Single ☐ Guardian ☐ Step-mother ☐ Foster parent

Name: _____ DOB: _____Social #: _____-_____-_____
Employer: _____ Work phone: (_____) _____-_____
Driver's license: _____ Expires: _____
Home phone: (_____) _____-_____ Cell phone: (_____) _____-_____

Who is accompanying the child today?

Name: _____ Relation: _____

Contact Email: _____ Do you have legal custody of this child? ☐ YES ☐ NO

In case of emergency please call:

Name: _____ Phone: (_____) _____-_____
Other family member seen by us: _____
Name of nearest relative not living with you: _____ Phone: (_____) _____-_____

Person responsible for account:

Name: _____ Relation: _____
Home: (_____) _____-_____ Work: (_____) _____-_____ Cell: (_____) _____-_____

Who may we thank for referring you?

Name: _____ Phone: (_____) _____-_____
Address: _____

Insurance Information: We are not in-network

Insured's name: _____ Insured's DOB: _____
Insured's Social #: _____-_____-_____ Relationship to patient: _____
Insured's Employer: _____ Employer's address: _____
Employer's Phone: (_____) _____-_____ Insurance Company Phone: (_____) _____-_____
Insurance Company Name: _____
Insurance Company Address: _____

We are affiliated with the following insurance plans: Aetna, Ameritas, Assurant, Cinga, Delta, Guardian, Humana, United Concordia and United Healthcare, which means we would be considered an out-of-network provider with other insurance companies. Most dental insurance pay out-of-network benefits, but please verify that your policy will cover treatment by an out-of-network provider before you come in for your appointment. Payment of services is due in full at the time services are rendered. This includes all new patient evaluation appointments, prophylaxis (professional cleanings), emergency evaluations, re-care appointments, and treatment sum of $200.00 or less. We will submit and file claims with all insurances. It is your responsibility to give accurate insurance information so that this can be done in a timely manner.

_____ _____
Signature of parent/guardian Date

Child's Pediatrician: _____ Pediatrician's Phone: (_____) _____-_____

Previous/Present Dentist: _____

Is your child currently under the care of a physician? □ Yes □ No

Please describe your child's current physical health: □ Good □ Fair □ Poor

Please list all drugs that the child is allergic to: _____
_____
_____

Please list all drugs that the child is currently taking: _____
_____
_____

Does your child have any of the following habits?

□ Thumb/finger sucking □ Nail biting □ Mouth breathing
□ Lip sucking/biting □ Nursing/bottle habits □ Nighttime grinding of teeth

Does your child have a heart condition (such as a heart murmur)? □ Yes □ No
Explain if YES: _____
If yes, child's cardiologist: _____ Cardiologist's Phone: (_____) _____-_____

Does your child have (or ever had) any of the following medical problems?

YES	NO		YES	NO		
□	□	Cancer	□	□	□	□ Hearing impairment
□	□	Diabetes	□	□	□	□ Any operations
□	□	Rheumatic Fever	□	□	□	□ Any hospital stays
□	□	HIV+ / AIDS	□	□	□	□ Kidney/Liver problems
□	□	Hemophilia	□	□	□	□ Handicaps/Disabilities
□	□	Asthma	□	□	□	□ Allergies
□	□	Hepatitis	□	□	□	□ Pregnant
□	□	Tuberculosis (TB)	□	□	□	□ Smoker
□	□	Chronic upper respiratory problems	□	□	□	□ ADD & ADHD
□	□	Convulsions/Epilepsy	□	□	□	□ Developmentally delayed
□	□	Abnormal bleeding	□	□	□	□ Autism/PDD-NOS

Please discuss any medical problems your child has had: _____
_____
_____

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 this office of any changes in my child's medical status. I also authorize the doctors and the dental staff to perform any necessary dental services my child may need. The responsible party is the parent who brings the child to the dental office, independent of what a divorce decree may state. Reimbursement must be made between divorced parents. We will not intervene.

★ Only 1 custodial parent/caregiver will be allowed in the treatment room with the patient during treatment. Switching between custodial parents/caregivers will NOT be allowed because of distraction to the patient caused during transitions.

★ VIDEO TAPING in the office is FORBIDDEN unless formal consent form Kerrville Pediatric Dentistry has been obtained prior to treatment. CELL PHONES should be turned off or on silent during any preventative or restorative treatment.

_____ _____
Signature of parent/guardian Date

_____ _____
Signature of person accompanying child Date

KERRVILLE
PEDIATRIC DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name(s): _____

TO THE PATIENT/GUARDIAN—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

I authorize Kerrville Pediatric Dentistry to communicate with outside dentists, physicians, pharmacies, insurance companies, and or their staffs, and/or any other health care professional, concerning my medical/dental health care and my billing/account records held by Kerrville Pediatric Dentistry. I further authorize the electronic, digital, or verbal communication of records or information between Kerrville Pediatric Dentistry and any of the above mentioned entities associated with dental treatment. All treatments, accidents, and or illnesses are covered by this release. I agree to hold harmless the doctors, staff, officers of Kerrville Pediatric Dentistry concerning the release of any dental/medical records.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jennifer Wildey - (830) 255-4197, - Fax: (830) 255-4197 e-mail: happyteeth@wildeypd.com

Address: 715 Hill Country Drive, Suite 5, Kerrville, TX 78028

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue to treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this Consent, complete the following:

Guardian's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.