We are pleased to welcome you to our practice. Please take a few minutes to completely fill out this form.
If you have any questions, we'll be happy to help.
We look forward to working with you to maintain your child's dental health.

1. Tell Us About Your Child

Child's Name____
Last First MI

Nickname ______________________ ☐Male ☐Female

Child's Birthdate_____/_____/_____ Child's Age ______

Child's Home # (_____)_____________________________

Child's Home Address_____________________________

____

Referred by_______________________________________

Guardian Marital Status: ☐Single ☐Married ☐Separated

☐ Widowed ☐Divorced ☐Domestic Partners

2. Mother's Information

Name ____

Birthdate _____/_____/_____ ☐Stepmother ☐Guardian

Employer____

Work # (_____)____________________________________

Home # (_____)____________________________________

Cell # (_____)_____________________________________

SS #____

E-mail Address:___________________________________

Is mother active duty military at this time? ☐Yes ☐No

3. Father's Information

Name ____

Birthdate _____/_____/______ ☐Stepfather ☐Guardian

Employer____

Work # (_____)____________________________________

Home # (_____)____________________________________

Cell # (_____)_____________________________________

SS #____

E-mail Address___________________________________

Is father active duty military at this time? ☐Yes ☐No

4. Person Responsible for Account

Name____

5. Primary Dental Insurance

Insurance Co. Name_________________________________

Insurance Co. Phone # (_____)______________________

Policy #______________________ Group #____________

Policy Owner's Name_____________________________

Relationship to patient____________________________

Policy Owner's Birth date ______/______/_________

Social Security # __________________________________

Policy's Owner's Employer ________________________

6. Secondary Dental Insurance (if applicable)

Insurance Co. Name_________________________________

Insurance Co. Phone # (_____)______________________

Policy #______________________ Group #____________

Policy Owner's Name_____________________________

Relationship to patient____________________________

Policy Owner's Birth date ______/______/_________

Social Security # __________________________________

Policy's Owner's Employer ________________________

7. Health History

Child's Physician_____________________________________

Phone (_____)____________________________________

Is the child under the care of a physician? ☐Yes ☐No

Ever been hospitalized / surgery? ☐Yes ☐No

Does your child have any allergies? ☐Yes ☐No

If so, please list_____________________________________

____

Is your child allergic to: ☐Latex ☐ Penicillin

☐Amoxicillin ☐Tetracycline ☐ Dental Anesthesia

☐Aspirin ☐Other(s): __________________________

____

Please list <u>all</u> medications and dosage the child is currently taking:____

____

Does your child require pre medication before dental treatment? ____ Yes ____No

Has the child ever had any of the following problems?

Please check all that apply:

☐Tonsillitis ☐Respiratory Problems
☐Asthma ☐Blood Transfusion(s)
☐Leukemia/Anemia ☐Diabetes/Hypoglycemia
☐Hemophilia ☐Abnormal Bleeding
☐High/Low Blood Pressure ☐Hepatitis
☐Liver/Kidney Problems ☐Cancer/Tumors
☐HIV/AIDS/ARC ☐Tuberculosis TB

☐Psychiatric Problems ☐Hyper Active/ADD
☐Fainting/Seizures ☐Cerebral Palsy
☐Heart Murmur ☐Rheumatic Fever
☐Congenital Heart Defect ☐Artificial Heart Valves
☐Scarlet Fever ☐Cleft lip/Palate

Please relate any other significant medical problems the child has: ____

____

***Dental History:**

- Is this your child's 1st time to the dentist? ☐Yes ☐No

- Has your child ever had complications following dental treatment? ☐Yes ☐No
  If yes, please explain: ____________________________

- Doe the patient have any oral habits?
  ☐ Thumb Sucking ☐Pacifier ☐Clenching ☐Chewing on objects ☐Grinding

- Does your child use a bottle or Sippy cup?
  ☐Yes* ☐No

*If yes, when is the usage of a bottle or Sippy cup occuring?

☐With meals only ☐Throughout the day ☐During bedtime/naptime

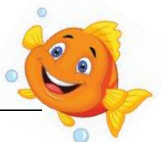
10. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I am the parent, guardian, or personal representation of the child listed above and there are no court orders in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. I certify that my dependent is covered by the insurance listed above and assign directly to Potomac Pediatric Dentistry 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. Potomac Pediatric Dentistry may use my child's health care information and may disclose such information to the above named insurance company and their agents for the purpose of obtaining payment for services and determining benefits or the benefits payable for related services.

11. In the event that I am unable to bring my child in for an appointment, the following individuals have my permission to accompany my child, as well as make any necessary decisions for my child's care. This includes consenting to any necessary treatment. IMPORTANT: The legal guardian must accompany their child/children for the first appointment.

NAME:	CONTACT NUMBER:
____	______________________
____	______________________
____	______________________

12. **Overdue Balance**
You are ultimately responsible for any balance on your account. If you have not paid your balance within 60 days of receipt of an invoice, a $5 billing charge will be added each month until resolved. Any balance remaining unpaid for 90 days or more will receive a final notice letter before being sent to collections. In the event that your account is sent to collections, you will be responsible for any and all costs incurred in the collection of this debt. This includes: an interest rate of 1.5% of the unpaid balance from the last date of service, attorney fees and court costs.
I have read, understood and agree to abide by this financial policy.

Parent/Guardian Signature______________________________________Date____________________



Consent for Use or Disclosure of Patient's Protected Health Information

**This form must be completed by the individual whose protected health information is to be disclosed or by a parent or guardian if the person is a minor under state law.*

NAME: ____

DATE OF BIRTH :______________________________**(for identification purposes)**

I hereby authorize **Potomac Pediatric Dentistry** to release the following personal health information for:

(Check all that apply)

☐ Dental service claims information

☐ Prescription, diagnostic, treatment, and/or care management services

☐ Reviews required by HHS or HIPAA-compliant health care operations

☐ Other (specify) ____

The above information may be released by:

☐ Phone ☐ Fax ☐ Mail ☐ E-mail ☐ Friend or Relative

My Consent

Effective: Today's Date ____

I want this consent to:

☐ Continue Indefinitely ☐ Effective Only Until _____________________________(date)

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my patient rights are identified in the practice's Notice of Privacy Practices.

Signature of Patient ____ Date _____________

Or, Guardian/Personal Representative ___________________________________ Date _____________