



Medical Dental History Form for Patients Under Age 18

PATIENT

Date _____

Patient's last name _____ First name _____ Middle initial _____

Prefers to be called _____ Hobbies, activities _____

Birth date _____ Sex Male Female Social Security # _____

School _____ Grade _____ Email address(es) _____

Home address _____ City, State, Zip code _____

Home phone () _____ - _____ Cell phone () _____ - _____

PARENT/GUARDIAN

Custodial parent(s) name(s) _____

Patient lives with (check all that apply) Mother Father Stepmother Stepfather Grandparent(s) Other _____

Father's full name _____ Title: Mr Dr Other _____

Occupation _____ Email address _____

Address (if different) _____

Home phone (if different) () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____

Mother's full name _____ Title: Mrs Ms Dr Other _____

Occupation _____ Email address _____

Address (if different) _____

Home Phone (if different) () _____ - _____ Cell phone () _____ - _____ Work phone () _____ - _____

DENTIST

Patient's Dentist _____ Address, City, State _____

Last seen _____ Reason _____ Next appointment _____

Other dentists/dental specialists now being seen: Name _____ City, State _____

Reason _____

GENERAL INFORMATION

What concerns you about your child's teeth? _____

What concerns your child about his/her teeth? _____

How does your child feel about orthodontic treatment? _____

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Describe any previous orthodontic treatment or consultations. _____

Does your child play a musical instrument? _____

Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____
Brother/sister name _____ age _____ had orthodontic treatment? Yes No If yes, where? _____
Have any other family members been treated in this office? Please name them. _____

FINANCIAL RESPONSIBILITY

Who is financially responsible for this account? _____
Address (if different than page 1) _____ City, State, Zip _____
Home phone () _____ - _____ Cell phone () _____ - _____ Email address(es) _____
Social Security # _____ Employer _____
Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary policy holder's full name _____ Birth date _____
Social Security # _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? Yes No Don't Know

Secondary policy holder's full name _____ Birth date _____
Social Security # _____ Relationship to patient _____
Address and phone (if not listed above) _____
Employer _____ Address _____
Insurance company _____ Group # _____ ID# _____
Does this policy have orthodontic benefits? Yes No Don't Know

MEDICAL INSURANCE

Policy holder's full name _____
Insurance Company _____

PHYSICIAN

Patient's Physician _____ City, State _____
Last seen _____ Reason _____ Next appointment _____
Most recent physical exam _____

Other physicians/health care providers being seen now:

Name _____ City, State _____
Reason _____
Name _____ City, State _____
Reason _____

Your answers are for office records only, and are confidential. A thorough medical history is essential to a complete orthodontic evaluation.

For the following questions, please mark yes, no, or don't know/understand (dk/u).

MEDICAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

- Birth defects or hereditary problems?
- Bone fractures or major injuries?
- Any injuries to face, head, neck?
- Arthritis or joint problems?
- Cancer, tumor, radiation treatment or chemotherapy?
- Endocrine or thyroid problems?
- Diabetes or low sugar?
- Kidney problems?
- Immune system problems?
- History of osteoporosis?
- Gonorrhea, syphilis, herpes, sexually transmitted diseases?
- AIDS or HIV positive?
- Hepatitis, jaundice, or other liver problems?
- Polio, mononucleosis, tuberculosis, pneumonia?
- Seizures, fainting spells, neurologic problems?
- Mental health disturbance or depression?
- History of eating disorder (anorexia, bulimia)?
- Frequent headaches or migraines?
- High or low blood pressure?
- Excessive bleeding or bruising, anemia?
- Chest pain, shortness of breath, tire easily, swollen ankles?
- Heart defects, heart murmur, rheumatic heart disease?
- Angina, arteriosclerosis, stroke or heart attack?
- Skin disorder (other than common acne)?
- Does your child eat a well-balanced diet?
- Vision, hearing, or speech problems?
- Frequent ear infections, colds, throat infections?
- Asthma, sinus problems, hayfever?
- Tonsil or adenoid condition?
- Does your child frequently breathe through his/her mouth?
- Has your child ever taken intravenous bisphosphonates such as Zometa (zoledronic acid), Aredia (pamidronate) or Didronel (etidronate) for bone disorders or cancer?
- Has your child ever taken oral bisphosphonates such as Fosamax (alendronate), Actonel(ridendronate), Boniva (ibandronate), Skelid (tiludronate) or Didronel (etidronate) for bone disorders?

Has your child had allergies or reactions to any of the following?

Yes No DK/U

- Local anesthetics (novocaine, lidocaine, xylocaine)
- Latex (gloves, balloons)
- Aspirin
- Ibuprofen (Motrin, Advil)
- Penicillin
- Other antibiotics
- Metals (jewelry, clothing snaps)
- Acrylics
- Plant pollens
- Animals
- Foods
- Other substances _____

DENTAL HISTORY

Now or in the past, has your child had:

Yes No DK/U

- Erupting teeth very early or very late?
- Primary (baby) teeth removed that were not loose?
- Permanent or extra (supernumerary) teeth removed?
- Supernumerary (extra) or congenitally missing teeth?
- Chipped or injured primary or permanent teeth?
- Any sensitive or sore teeth?
- Any lost or broken fillings?
- Jaw fractures, cysts, infections?
- Any teeth treated with root canals or pulpotomies?
- Frequent canker sores or cold sores?
- History of speech problems or speech therapy?
- Difficulty breathing through nose?
- Mouth breathing habit or snoring at night?
- History of speech problems?
- Frequent oral habits (sucking finger, chewing pen, etc)?
- Teeth causing irritation to lip, cheek or gums?
- Tooth grinding or clenching?
- Clicking, locking in jaw joints?
- Soreness in jaw muscles or face muscles?
- Has your child been treated for "TMJ" or "TMD" problems?
- Any broken or missing fillings?
- Any serious trouble associated with previous dental treatment?
- Has your child ever been diagnosed with gum disease or pyorrhea?

PATIENT HEALTH INFORMATION

Do you think that any of your child's activities affect his/her face, teeth or jaws? How? _____

List any medication, nutritional supplements, herbal medications or non-prescription medicines, including fluoride supplements that your child takes.

Medication _____ Taken for _____

Medication _____ Taken for _____

Medication _____ Taken for _____

Does your child take antibiotic pre-medication before any dental procedures? _____

Does your child have (or ever had) a substance abuse problem? _____

Does your child chew or smoke tobacco? _____

Have you noticed any unusual changes in your child's face or jaws? _____

Any other physical problems? _____

FAMILY MEDICAL HISTORY

Have the parents or siblings ever had any of the following health problems? If so, please explain.

Bleeding disorders _____ Diabetes _____

Arthritis _____ Severe allergies _____

Unusual dental problems _____ Jaw size imbalance _____

Other family medical conditions? _____

How often does your child brush? _____ Floss? _____

RELEASE AND WAIVER

I authorize release of any information regarding my child's orthodontic treatment to my dental and/or medical insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____

MEDICAL HISTORY UPDATES OR CHANGES

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Changes _____

Parent/Guardian Signature _____ Date _____

Dental Staff Signature _____ Date _____

Financial Agreement:

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All Patients must complete our "Patient Information Form" prior to being seen by the Dental Professional
- Full Payment is due at the time of Service
- We accept CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTER CARD, DISCOVER AND CARE CREDIT
- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of service.

Adult Patients

- Adult patients are responsible for payment in full at the time of service.

Minors Accompanied by an Adult

- The adult accompanying a minor, his/her parent, or guardians are responsible for payment in full at the time of service

Unaccompanied Minors

- The parents or guardians are responsible for payment in full at time of service. Non – emergency treatment will be denied unless charges have been pre-authorized. Providers may choose to avoid treating a minor without an adult present at his or her own discretion.

Insurance

- This Practice provides insurance company billing as a courtesy to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of the service. This amount maybe subject to adjustment, when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services which can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of the dental services that exceed the particular plan's limitations. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by the staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to. However, if you are paid by the insurance company instead of, you then become responsible for the total account balance and payment would be expected immediately.
- If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available
- You, as a patient, are always responsible for any charges that are not covered by your insurance.

NSF Fee

- All payment returned due to non-sufficient funds will be subject to a NSF fee of \$25.00

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Patient or Guardian Signature

Date

**Notice of information and Privacy Practices
HIPAA Communication Form**

Patient Name: _____

DOB: _____

I have been given a copy of Professional Dental Alliance practice (“Practice”), *Notice of Information and Privacy Practices* (“Notice”), which describes how my health information is used and shared. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy by contacting the Privacy Officer at (765) 698-2500, or by visiting the Practice’s web site.

Patient privacy is important to us. Our policy is to keep patient health information confidential and not disclose such information without your consent or written authorization unless otherwise required by federal or state privacy laws.

Please provide us with information with whom we can communicate with concerning your care. We would also like to obtain information regarding alternative communication preferences so that we know the best way to contact you with appointment reminders or other information related to your care.

Please note: If you have someone accompany you in the treatment area, we will assume this person is entitled to receive information regarding your care and we can freely discuss your health information.

You are free to make changes to your preferences at any time. Updates must be made in person and a new form completed.

Please provide the names and relationship to patient for those individuals you will need or want your health information to be provided. This includes family members, friends, organizations or caregivers/babysitters:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Communication – Our practice is to protect the privacy of our patients while ensuring our patients are kept well informed of their appointments and other information. As a service to our patients, we will communicate appointment reminders and other information via text message, email or via phone. Limited information will be left when leaving a voice message. Medical information will not be shared when leaving a voice message. Please inform our team if you would prefer we use an additional communication preference for appointment reminders or other information related to your care.

My signature below acknowledges that I have been offered and/or provided with a copy of the Notice of Information and Privacy Practices:

Patient, Guardian, or Personal Representative Signature

Date

Print Name and/or Personal Representative’s Title(e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

Non – Discrimination Policy

Professional Dental Alliance and its affiliates comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Professional Dental Alliance and affiliates do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

If requested, Professional Dental Alliance and affiliates provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

If you need these services, contact the Office Manager at the practice location.

If you believe that Professional Dental Alliance and affiliates have failed to provide these services or discriminated in another way based on race, color, national origin, age, disability, or sex, you can file a grievance with:

Kiena P Nutter- Compliance Coordinator
11 S Mill St
New Castle, PA 16101
724.698.2905
nutterk@nadentalgroup.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Kiena P Nutter, Compliance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

V.1 April 19, 2017

ADA Dental Patient Rights and Responsibilities Statement

Your dentist is the best source of information about your dental health and wants you to feel comfortable about your dental care. Maintaining healthy teeth and gums means more than just brushing and flossing every day and visiting your dentist regularly. As an informed dental patient, it also means knowing what you can expect from your dentist and dental care team and understanding your role and responsibilities in support of their efforts to provide you with quality oral health care.

The rights and responsibilities listed below do not establish legal entitlements or new standards of care, but are simply intended to guide you through the development of a successful and collaborative dentist-patient relationship.

Patient Rights

1. *You have a right to* choose your own dentist and schedule an appointment in a timely manner.
2. *You have a right to* know the education and training of your dentist and the dental care team.
3. *You have a right to* arrange to see the dentist every time you receive dental treatment, subject to any state law exceptions.
4. *You have a right to* adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
5. *You have the right to* know what the dental team feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
6. *You have a right to* an explanation of the purpose, probable (*short and long term*) results, alternatives and risks involved before consenting to a proposed treatment plan.
7. *You have a right to* be informed of continuing health care needs.
8. *You have a right to* know in advance the expected cost of treatment.
9. *You have a right to* accept, defer or decline any part of your treatment recommendations.
10. *You have a right to* reasonable arrangements for dental care and emergency treatment.
11. *You have a right to* receive considerate, respectful and confidential treatment by your dentist and dental team.
12. *You have a right to* expect the dental team members to use appropriate infection and sterilization controls.
13. *You have a right to* inquire about the availability of processes to mediate disputes about your treatment.
14. You have the right to receive access to treatment and accommodations that are available regardless of race, sex, age, creed, sexual orientation, national origin, religion, handicap, or marital status

Patient Responsibilities

1. *You have the responsibility to* provide, to the best of your ability, accurate, honest and complete information about your medical history and current health status.
2. *You have the responsibility to* report changes in your medical status and provide feedback about your needs and expectations.
3. *You have the responsibility to* participate in your health care decisions and ask questions if you are uncertain about your dental treatment or plan.
4. *You have the responsibility to* inquire about your treatment options and acknowledge the benefits and limitations of any treatment that you choose.
5. *You have the responsibility for* consequences resulting from declining treatment or from not following the agreed upon treatment plan.
6. *You have the responsibility to* keep your scheduled appointments.
7. *You have the responsibility to* be available for treatment upon reasonable notice.
8. *You have the responsibility to* adhere to regular home oral health care recommendations.
9. *You have the responsibility to* assure that your financial obligations for health

Areas within the practice may be limited to some requests for accommodations specifically where facility must maintain a sterile environment