



LWSS FAMILY DENTISTRY, LTD ORTHODONTICS & DENTISTRY FOR CHILDREN

lwssfamlydentistry.com

PERSONAL, MEDICAL AND DENTAL HISTORY

We are continually concerned with your health and the care that is rendered to you. It is therefore important to update this information every 2 years . If you have any questions, please feel free to ask one of our staff members to assist you. Please print clearly.

PATIENT INFORMATION

Date _____

Name of Minor Child _____
First M.I. Last

Sex: ___M ___F Age _____ Birthdate _____ Nickname _____

Home Address _____
Street City State Zip

Child's S.S. # _____ Who may we thank for referring you? _____

RESPONSIBLE PARTIES / INSURANCE INFORMATION

Father's/Guardian's Name _____

Relationship to patient _____

Address (If different from patient's) _____

Home Phone _____ Work Phone _____

Cell Phone _____

Employer _____
RANK/RATE

Employer Address _____
How long employed

City, State, Zip _____

Email _____

S.S. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? __Yes __No

Insurance Co. _____

Group # _____ Policy ID # _____

Ins. Co. Address _____

City, State, Zip _____

Mother's/Guardian's Name _____

Relationship to patient _____

Address (If different from patient's) _____

Home Phone _____ Work Phone _____

Cell Phone _____

Employer _____
RANK/RATE

Employer Address _____
How long employed

City, State, Zip _____

Email _____

S.S. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? __Yes __No

Insurance Co. _____

Group # _____ Policy ID # _____

Ins. Co. Address _____

City, State, Zip _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Address _____
Street City State Zip

Home Phone _____ Work Phone _____

AUTHORIZATION

I authorize the following person(s) to bring my child in for appointments and approve doctor recommended treatment.
I also give this practice my permission to release the doctor's recommended future treatment to said authorized person(s):

Name _____

Name _____

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

Signature _____

DENTAL/MEDICAL HEALTH HISTORY

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient ID # _____

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/Finger Yes No

Suck/Bite Lip Yes No

Bite/Chew Nails Yes No

Chew hard objects (pencils, etc.) Yes No

Grind teeth Yes No

Clench Jaws Yes No

Date of last dental visit _____

Previous Dentist _____

Address _____

Has your child had difficulty with previous dental visits? Yes No

Has your child ever had any of the following:

Asthma Yes No

Handicap/Disabilities Yes No

Cancer Yes No

Tuberculosis Yes No

Hepatitis Yes No

Diabetes Yes No

HIV/AIDS Yes No

Rheumatic Fever Yes No

Hemophilia Yes No

Congenital Heart Defect Yes No

Abnormal Bleeding Yes No

Heart Murmur Yes No

Stomach, Liver, or Kidney Problems Yes No

Convulsions/Epilepsy Yes No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses _____ When? _____

Is your child taking any medications? Yes No (If yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc)? Yes No

(If yes, please describe) _____

Does your child have a history of allergies to any other substance (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

FINANCIAL ARRANGEMENTS: Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment:

- Cash Personal Check Charge Cards

I hereby apply for treatment by the above dentists, their associates and/or assistants. Treatment may include x-rays, injections and/or such other office procedures they deem necessary.

If health care workers are accidentally exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Payment policies of LWSS Family Dentistry have been explained to me, and I hereby acknowledge and accept responsibility for payment of all charges incurred with the above dentists, acknowledging that they may obtain a credit report in order to establish credit.

It is understood that this responsibility extends to the total charges without regard to possible insurance benefits, and that any insurance benefits which may be provided will be considered part of my financial resource only and will not waive my responsibility. If payment for such medical services is not made when due, the undersigned agrees to pay all costs of collecting the medical bill, including 33 1/3% attorneys' fees and costs, skip tracing and third party services. I have read and fully understand the meaning and consequences of the above statement.

INTEREST RATE: 1 1/2 % PER MONTH (Equivalent 18% APR) on that part of accounts due over 60 days (Minimum interest rate \$.50).

PATIENTS WITHOUT INSURANCE - PAYMENT IS DUE AT THE TIME OF THE VISIT

A charge of \$25.00 will be made for appointments broken or cancelled without 24 hour notice. A charge of \$25.00 will be made for returned checks.

PATIENT _____ RESPONSIBLE PARTY _____

DATE _____