Medical History Form

I. GENERAL INFORMATION

Residence address:____Phone: ____________________________
City:____State:_____________Zip code:________________________
Father:_________________________________Birthdate:____________Social security #:____________________
Employed by:____Phone number: ______________________________
Cell phone number:________________________Email address: ______________________________________

Mother:_________________________________Birthdate:____________Social security #: ____________________
Employed by:____Phone number:_______________________
Cell phone number:________________________Email address: ______________________________________

Child's Name (first, last):_______________________________________Nickname ___________________________
Age:________Birthdate:_____________________________Place of Birth:__________________________Gender M / F
Names & Ages of Siblings: ____

Attends what school:____________________________________ Referred by: _____________________________

II. MEDICAL HISTORY (circle appropriate condition)

1. Has your child ever experienced any of the following:
   - A. Cerebral palsy, seizures, convulsions, fainting, loss of consciousness, trauma to head, recurrent headaches..........Yes.........No
   - B. Sensory disorders of seeing or hearing..........Yes.........No
   - C. Behavioral, learning, or communication problems, excessive nervousness..........Yes.........No
   - D. Congenital heart disease, heart murmur, heart damage from rheumatic fever..........Yes.........No
   - E. History of chest pains or high blood pressure..........Yes.........No
   - F. Prolonged bleeding, blood dyscrasias or diseases, blood transfusions or HIV infection..........Yes.........No
   - G. Cystic fibrosis, pneumonia, asthma, shortness of breath, difficulty breathing..........Yes.........No
   - H. Stomach, liver, intestinal problems, hepatitis, jaundice..........Yes.........No
   - I. Pregnancy or possible pregnancy, kidney or bladder disease..........Yes.........No
   - J. Diabetes, thyroid disease, or other glandular problems..........Yes.........No
   - K. Limitations of arms or legs, joint replacement, or muscular dystrophy..........Yes.........No
2. Has your child ever experienced the following:
   - A. Allergy to any medication?________
     If so, what medication and what was the reaction? ____
   - B. Allergy or sensitivity to other materials or chemicals, such as LATEX, NUTS, DYES etc.?__________________________
     If so, which material and what was the reaction? ____
3. Is your child currently on any medication?________
   If yes, please list ____
4. Does your child have any other medical condition or syndrome, not reflected in the above questions? ________
   If yes, please list ____
5. Has your child ever been hospitalized?________
   If yes, for what?____
6. Child's physician or pediatrician____
   Address____Phone______________________
7. Date of last medical exam____

III. DENTAL HISTORY

1. Is this your child's first visit to a dentist? ____
2. Who is your family dentist? ____
3. Has your child had a toothache recently? ____
4. Has your child ever injured their mouth, teeth, or jaw?____
5. Does (or has) your child have (or had) a sucking habit beyond one year of age?__________
   If yes, check: Thumb_____Finger____Pacifier_____Other_____
6. Does (or has) your child have (or had) any other oral habits?____________
   If yes, check: Nail biting_____Teeth grinding______Other_____
7. Does your child have a history of any TMJ clicking or popping? ______________________________________

IV. DENTAL DISEASE PROBLEMS

1. How often are your child's teeth brushed?_________times per_______
2. Does your child use dental floss?__________________________
3. Does your child use fluoride toothpaste?______________________
4. What is your child's drinking water source?
   City_____Well____Other_______
5. Does your child drink fruit juice or soda pop?_______
   If so, how many ounces per day?______________

__________initials

Treatment and Financial Consent

Every effort is being made to keep down the cost of dental care. You can help by making your payment at the time of your visit. You will be given an estimate of the approximate total fee at the beginning of any necessary treatment and definite financial arrangements will be made with you at that time.

We request that services rendered on your child's FIRST visit be paid on the day of the visit. Several methods of payment are available after that visit which we will be happy to discuss with you. They are as follows:

1. Payment at time of visit is the customary method.
2. Mastercard, Visa, or Discover
3. Insurance – We will file insurance claims as a courtesy to you at no charge. You must provide us with a current insurance card that shows mailing address and telephone number for benefit determination.
4. CareCredit - CareCredit is a flexible patient payment program, specifically designed for healthcare expenses, that makes it easier for you to get the treatment or procedures you want and need. CareCredit lets you begin your treatment or procedure immediately—then pay for it over time with low monthly payments that are easy to fit into your monthly budget.

We file dental claims electronically within 24 hours of service. If your insurance company will not accept e-claims, we will file the claim on a standard insurance claim form. **It is your responsibility to provide the office with the correct insurance information.**

If benefits are to be assigned to our office, we must have a Dental Insurance Authorization & Release of Information form (see below) on file that is signed by the insured or responsible party. The office policy regarding payments from your insurance company is that we will file claims only twice for a specific claim with a grace period of 30 days. If payment is not received within 30 days, a statement will be sent to you requesting payment in full and suggesting you contact your insurance company.

DENTAL INSURANCE AUTHORIZATION & RELEASE OF INFORMATION

I hereby authorize payment of the group insurance benefits directly to the Dental Office of Pediatric Dentistry of Noblesville otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

I understand that it is my responsibility to provide the Dental Office with my current insurance information to properly file claims.

If my insurance company has not made payment to the Dental Office within 30 days of the treatment date, I agree to pay the balance due in full at that time. I understand that interest will be charged on any unpaid amounts more than 60 days past due at an annual percentage rate of 18%.

X____
Insured or Responsible Party

____
Date

Please remember that you are responsible for payment of all fees to this office. Your dental insurance plan is designed to share in the cost of your dental treatment. It may not cover the total cost of your treatment. Your insurance policy is a contract between you and your insurance company. The insurance company has no obligation to our office.

We are happy to cooperate with you and the insurance company in order to help you receive the maximum benefits available under your policy.

METHOD OF PAYMENT (please check)

CASH______CREDIT CARD_______INSURANCE______MEDICAID______CARE CREDIT______OTHER______

CONSENT

YOUR CHILD IS A MINOR, THEREFORE IT IS NECESSARY THAT A SIGNED PERMISSION BE OBTAINED FROM A PARENT OR LEGAL GUARDIAN BEFORE ANY NECESSARY DENTAL SERVICE CAN BE PERFORMED. **I GRANT JOE E. FORGEY, D.D.S., CHAD O. HAZELRIGG, D.D.S. AND CHARLES T. FUHRER III, D.D.S.** PERMISSION TO PROVIDE MY CHILD'S DENTAL EXAM AND TREATMENT AND I WILL BE RESPONSIBLE FOR THE COST OF THE DENTAL CARE. I UNDERSTAND THAT I AM COMPLETELY FINANCIALLY RESPONSIBLE FOR ALL TREATMENT INCURRED BY THE ABOVE NAMED PATIENT IN THIS OFFICE, INCLUDING ANY AMOUNTS NOT PAID BY MY INSURANCE COMPANY (IF ANY) WITHIN 30 DAYS OF TREATMENT. I UNDERSTAND INTEREST WILL BE CHARGED ON ANY UNPAID AMOUNTS MORE THAN 60 DAYS PAST DUE AT AN ANNUAL PERCENTAGE RATE OF 18%. I PROMISE TO PAY ANY LEGAL INTEREST ON THE BALANCE DUE, TOGETHER WITH ANY COLLECTION COSTS OR ATTORNEY FEES INCURRED TO EFFECT COLLECTION OF THIS ACCOUNT SHOULD MY ACCOUNT BE TURNED OVER TO A THIRD PARTY.

SIGNED____
Parent or Guardian Date