APPT TIME _____
ASSISTANT _____ LDV _____
NEW PATIENT / EXISTING PATIENT
CHART # _____

PATIENT NAME _____
FIRST, MIDDLE, LAST NAME

DATE OF BIRTH _____ **AGE** _____ **GENDER** ☐ MALE ☐ FEMALE

PHONE NUMBER HOME _____ MOBILE _____ WORK_____

ADDRESS _____
STREET APARTMENT # CITY, STATE, ZIP CODE

EMAIL ADDRESS _____

PATIENT HEALTH INFORMATION

Date of last dental visit _____ Reason for this visit _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? PLEASE CHECK YES or NO

☐YES ☐NO *AIDS*	☐YES ☐NO *Epilepsy*	☐YES ☐NO *Kidney Disease*	☐YES ☐NO *Stomach Problems*
☐YES ☐NO *Allergies*	☐YES ☐NO *Excessive Bleeding*	☐YES ☐NO *Liver Disease*	☐YES ☐NO *Stroke*
_____	☐YES ☐NO *Fainting*	☐YES ☐NO *Mental Disorders*	☐YES ☐NO *Tuberculosis*
_____	☐YES ☐NO *Glaucoma*	☐YES ☐NO *Nervous Disorders*	☐YES ☐NO *Tumors*
☐YES ☐NO *Anemia*	☐YES ☐NO *Growths*	☐YES ☐NO *Pacemaker*	☐YES ☐NO *Ulcers*
☐YES ☐NO *Arthritis*	☐YES ☐NO *Hay Fever*	☐YES ☐NO *Pregnancy*	☐YES ☐NO *Venereal Disease*
☐YES ☐NO *Artificial Joints*	☐YES ☐NO *Head Injuries*	*Due Date:*_____	☐YES ☐NO *Codeine Allergy*
☐YES ☐NO *Asthma*	☐YES ☐NO *Heart Disease*	☐YES ☐NO *Radiation Treatment*	☐YES ☐NO *Penicillin Allergy*
☐YES ☐NO *Blood Disease*	☐YES ☐NO *Heart Murmur*	☐YES ☐NO *Respiratory Problems*	☐YES ☐NO *OTHER:*
☐YES ☐NO *Cancer*	☐YES ☐NO *Hepatitis*	☐YES ☐NO *Rheumatic Fever*	☐ _____
☐YES ☐NO *Diabetes*	☐YES ☐NO *High Blood Pressure*	☐YES ☐NO *Rheumatism*	☐ _____
☐YES ☐NO *Dizziness*	☐YES ☐NO *Jaundice*	☐YES ☐NO *Sinus Problems*	☐ _____

Current Medications? _____

Name of Pediatrician/Physician _____ Phone _____

Has your child ever had any complications following dental treatment? ☐ YES ☐ NO
If yes, please explain _____

Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ YES ☐ NO
If yes, please explain _____

Is your child currently under the care of a physician? ☐ YES ☐ NO
If yes, please explain _____

Does your child have any health problems that need further clarification? ☐ YES ☐ NO
If yes, please explain _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If patient/child ever has any change in health, I will inform the doctor at the next appointment without fail.

_____ _____
Signature of Parent/Guardian **Date**

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐Another patient, relative ☐Dental Office
☐Pediatrician ☐Internet ☐Radio ☐TV ☐Facebook ☐Movies ☐TV & Movies ☐Billboard ☐Other _____

Name of person referring you to our practice _____

FOR OFFICE USE ONLY

***WEIGHT*_____ *BP* _____/_____ *PULSE* _____ *EXIT TIME* _____ *Dr Reviewing Med HX* _____**

***REFERRAL TO SPECIALIST* ☐ *YES* ☐ *NO* _____**

***NEXT VISIT*_____**

PARENT/GUARDIAN INFORMATION

NAME _____ □ MALE □ FEMALE □ Married □ Single □ Other _____

DATE OF BIRTH _____ **EMAIL ADDRESS** _____

TELEPHONE # HOME _____ MOBILE _____WORK _____ Best time to call _____

ADDRESS _____

Street, Apt #, City, State, Zip Code (IF SAME AS PATIENT ENTER "SAME")

EMPLOYER NAME _____ **OCCUPATION** _____

EMERGENCY CONTACT INFORMATION

NAME _____ □ MALE □ FEMALE

TELEPHONE # HOME _____ MOBILE _____ WORK _____

ADDRESS _____

STREET APARTMENT # CITY, STATE, ZIP CODE

RELATIONSHIP TO PATIENT _____

PRIVATE INSURANCE INFORMATION

Insurance Plan Name & Address _____

_____

Name of Insured _____ **SSN#** _____

Insured's Date of Birth _____ **ID #** _____ **Group #** _____

Insured's Address _____

STREET APARTMENT # CITY, STATE, ZIP CODE

Insured's Employer Name _____

Patient's relationship to Insured □*Self* □*Spouse* □*Child* □*Other* _____

CONSENT FOR SERVICES

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. A service charge of 1 1/2% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their consent.

I _____ , also give consent for my child _____ to have a dental exam, dental radiographs (x-rays), flouride and a prophylaxis (cleaning).

_____

Signature of Parent/Guardian

_____

Relationship to Patient

_____

Date

1. What does HIPAA stand for?

HIPAA is an acronym for Health Insurance Portability & Accountability Act which was passed by Congress in 1996

2. Why should I sign now?

Signing now simply lets us know you received the HIPAA Notice Practice. Of course you can choose not to sign.

3. What happens if I don't sign this acknowledgement form?

First, you need to know we will provide you timely care and treatment whether or not you sign form. Second, you choose not to sign the form, we will note your choice in the bottom of the acknowledgment form and ho you take a copy of the Notice.

4. Is my signature just acknowledging receipt of this notice?

Yes. By signing this acknowledgment form we then can show the Department of Health & Human Services that we are complying with one of the major rules of HIPAA to make sure we give every patient the opportunity to have the Notice. You may refuse to sign this form!

5. Why is this notice so long compared to the ones I received from my financial institution, my credit card company, or my life insurance company?

Those companies are subject to a different set of private rules under the Graham/Leach Act while all healthcare organizations are subject to HIPAA and (where indicated) state laws.

6. Are you doing anything different with my health information now than you did before HIPAA?

Actually, we are going to guard you medical information even more closely. We have developed policies a procedures for our staff throughout (Heroes Dental) to follow, to make certain your medical (dental) information is shared only with those needing your information for treatment, payment, or healthcare operations.

7. Is this HIPAA Notice and acknowledgment form only for Heroes Dental?

Yes; however, all healthcare organizations such as hospitals, physician's offices, outpatient surgery centers, and home care or hospice care services are subject to HIPAA effective April 14, 2003. These other organizations will have their own Notice and acknowledgment form you will need to sign when you receive services from them.

8. After I sign this acknowledgment, then what happens?

We will place you form in your medical records and note your choice in our computer system. When you return for the same type of service or another service here at Heroes Dental we will need to ask you if you have received our HIPAA Privacy Notice. Since you have received one today you just need to let us know then that you already have one.

9. What am I going to be paying out because of signing?

Signing our HIPAA Privacy Notice acknowledgment form has NO bearing on your current payment arrangements.

10. Am I expected to sign this acknowledgement form without reading the Privacy Notice?

Yes. You are simply going on record that you have the Privacy Notice which we are required by the law that is the

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided the opportunity to read a copy of Heroes Dental Notice of Privacy Practices.

Patients Name: _____ Date of Birth: _____

Patient or Guardian Signature: _____ Date: _____

Clinical information will not be provided to anyone other than to you Heroes Dental as noted in the Notice of Privacy Practices. If you would like us to inform family members or other persons, if any, about your general medical condition and/ or your diagnosis (including treatment, payment and health care operations), please list those individuals here:

_____
_____
_____
_____

FOR OFFICE USE ONLY:

We have made every effort to obtain written acknowledge of receipt of out Notice of Privacy from this patient but it could not be obtained because:

- ☐ Individual refuse to sign
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgment
- ☐ A communication barrier prevented ECT from obtaining acknowledgment
- ☐ Other: (please provide specific details) _____

Employee Signature: _____ Date: _____

Dental Risk Assessment Questionnaire

Parents and caregivers – use this form to tell us about the oral health of your child. This will be part of your child's health record.

Parent/Guardian Name _____ **Date** _____

Child's Name _____ **Child's Age** _____

	Yes	No
1. Does your family drink water with fluoride in it or do your children take fluoride tablets?	☐	☐
2. Does your child use a toothpaste with fluoride in it?	☐	☐
3. Do you help your child with toothbrushing?	☐	☐
4. Have you or your children ever had a bad dental experience?	☐	☐
5. Have any of your children ever had cavities?	☐	☐
6. Does your child complain of mouth pain?	☐	☐
7. Does your child take a bottle to bed?	☐	☐
8. Does your child walk around drinking from a bottle or cup?	☐	☐

9. How many times does your child eat a snack each day? _____

10. How many bottles does your child have each day? _____

11. How is your own dental health? ☐ Good ☐ Fair ☐ Poor

	Yes	No
12. Do you have any cavities?	☐	☐
13. Do your gums bleed?	☐	☐

Did you know?

For every 100 school children, more than 5 days of school per year are lost due to dental disease.

Good dental health is important!

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See **http://www.dshs.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

First Dental Home

Texas Health Steps
TEXAS Department of State Health Services
EF08-12879 Rev-1108

Oral Health Questionnaire

Child's Name_____ **Date**_____

Child's Age _____ **Child's Date of Birth** _____

HEALTH HISTORY	**Yes**	**No**
Did the birth mother have any problems during pregnancy?	☐	☐
Was your child premature?	☐	☐
Was your child's birth weight low?	☐	☐
Were there any complications at birth?	☐	☐
Has your child been ill?	☐	☐
Is your child on any medications?	☐	☐
DIET AND NUTRITION		
Is/was your child breastfed?	☐	☐
Does your child sleep with a bottle?	☐	☐
Does your child drink from a cup?	☐	☐
Does your child walk around drinking from a bottle or cup?	☐	☐
Is your child on a special diet?	☐	☐
How many times does your child snack each day? _____		
How many bottles does your child have each day? _____		
FLUORIDE ADEQUACY		
Do you know the fluoride level of your water?	☐	☐
Do you have well water?	☐	☐
Do you use bottled water?	☐	☐
Do you use a water conditioner or filtration system?	☐	☐
If yes, please list _____		
Do you use fluoride toothpaste for your child?	☐	☐
ORAL HABITS		
Does your child use a pacifier?	☐	☐
Does your child suck a thumb or fingers?	☐	☐
Does your child grind his/her teeth day or night?	☐	☐
INJURY PREVENTION		
Is your child walking?	☐	☐
Is your home childproofed?	☐	☐
Do you use a car seat for your child?	☐	☐
Has your child had an injury to his/her mouth or face?	☐	☐
ORAL DEVELOPMENT		
Does your child have any teeth?	☐	☐
Child's age (in months) when the first tooth came in? _____		
Has your child had teething problems?	☐	☐
Have you noticed any problems with your child's mouth or teeth?	☐	☐
Does your child complain of mouth pain?	☐	☐
Have any of your children ever had cavities?	☐	☐
Have you or your children ever had a bad dental experience?	☐	☐
ORAL HYGIENE		
Do you clean your child's gums/teeth?	☐	☐
Do you use a toothbrush to clean your child's teeth?	☐	☐
Do you use toothpaste to clean your child's teeth?	☐	☐

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