Hope DENTAL PROFESSIONALS

Today's date_____ How did you hear about our office?_____

Child's Name First_____ Middle _____ Last_____

Nickname_____ Date of birth_____ Gender: Male or Female

Parent/Guardian Information: Please provide information for both parents

Mr.
Name Ms. _____ Preferred Name_____Date of Birth_____

Address _____ Apt _____City _____State _____Zip_____

Phone (H)_____(Work)_____ext_____(cell)_____

Best time and place to reach you _____email address_____

Social Security _____ Gender: M or F Are You: Single Married Divorced Separated Widowed

Place of employment _____Insurance Information_____

Parent/Guardian Information: Please provide information for both parents

Mr.
Name Ms. _____ Preferred Name _____ Date of Birth_____

Address _____ Apt _____City _____State _____Zip_____

Phone (H)_____(Work)_____ext_____(cell)_____

Best time and place to reach you _____email address_____

Social Security _____ Gender: M or F Are You: Single Married Divorced Separated Widowed

Place of employment _____Insurance Information_____

Emergency Contact Information: Person not living at your residence.

Mr.
Mrs.
Name Ms._____Relationship to patient_____

Address_____Apt #_____City_____State_____Zip _____

Child Health/Dental History Form

Patient's Name LAST FIRST INITIAL	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address PO OR Mailing Address CITY	STATE	ZIP CODE
Phone Home work Cell	Sex M □ F □	

Have you (the parent/guardian) or the patient had any of the following diseases or problems?..... □ Yes □ No

1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood?

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

□ Anemia	□ Cancer	□ Epilepsy	□ HIV/+/AIDS	□ Mononucleosis	□ Thyroid
□ Arthritis	□ Cerebral Palsy	□ Fainting	□ Immunizations	□ Mumps	□ Tobacco/Drug Use
□ Asthma	□ Chicken Pox	□ Growth Problems	□ Kidney	□ Pregnancy (teens)	□ Tuberculosis
□ Bladder	□ Chronic Sinusitis	□ Hearing	□ Latex allergy	□ Rheumatic fever	□ Venereal Disease
□ Bleeding disorders	□ Diabetes	□ Heart	□ Liver	□ Seizures	□ Other_____
□ Bones/Joints	□ Ear Aches	□ Hepatitis	□ Measles	□ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician Phone

Child's History	Yes	No
1. Is the child taking any prescription and/or over the counter medications supplements at this time?.....	[ ]	[ ]
If yes, please list: _____	[ ]	[ ]
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain_____	[ ]	[ ]
3. Is the child allergic to anything else, such as certain foods? If yes, please explain?_____	[ ]	[ ]
4. How would you describe the child's eating habits?_____	[ ]	[ ]
5. Has the child ever had a serious illness? If yes, when:_____Please describe:_____	[ ]	[ ]
6. Has the child ever been hospitalized?.....	[ ]	[ ]
7. Does the child have a history of any other illnesses? If yes, please list_____	[ ]	[ ]
8. Has the child ever received a general anesthetic?.....	[ ]	[ ]
9. Does the child have any inherited problems?.....	[ ]	[ ]
10. Does the child have any speech difficulties?.....	[ ]	[ ]
11. Has the child ever had a blood transfusion?.....	[ ]	[ ]
12. Is the child physically, mentally, or emotionally impaired?.....	[ ]	[ ]
13. Does the child experience excessive bleeding when cut?.....	[ ]	[ ]
14. Is the child currently being treated for any illnesses?.....	[ ]	[ ]
15. Is this the child's first visit to a dentist?.....	[ ]	[ ]
16. Has the child had any problem with dental treatment in the past?.....	[ ]	[ ]
17. Has the child ever had dental radiographs (x-rays) exposed?.....	[ ]	[ ]
18. Has the child ever suffered any injuries to the mouth, head or teeth?.....	[ ]	[ ]
19. Has the child had any problems with the eruption or shedding of teeth?.....	[ ]	[ ]
20. Has the child had any orthodontic treatment?.....	[ ]	[ ]
21. What type of water does your child drink? □ City water □ Well water □Bottle water □ Filtered water	[ ]	[ ]
22. Does the child take fluoride supplements.....	[ ]	[ ]
23. Is fluoride toothpaste used?.....	[ ]	[ ]
24. How many times are the child's teeth brushed per day?_____when are the teeth brushed?_____	[ ]	[ ]
25. Does the child suck his/her thumb, fingers or pacifier?.....	[ ]	[ ]
26. At what age did the child stop bottle feeding? Age_____Breast feeding? Age_____	[ ]	[ ]
27. Does child participate in active recreational activities?.....	[ ]	[ ]

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature_____Date_____

Doctor Signature_____Date_____

Hope DENTAL PROFESSIONALS

Your Privacy Is Important to Us

Acknowledgement of Receipt of Notice of Privacy Policies

(Minor)

I have received a copy of the Notice of Privacy Practices of Hope Dental Professionals. I hereby authorize, as indicated by my signature below, Hope Dental Professionals to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the patient consent form.

Child's name_____ Date _____

Parent signature_____ Address_____

Please check your preferred means of communication:

- □ You may contact me at my home telephone number_____
- □ You may contact me on my mobile telephone number_____
- □ You may contact me on my work telephone number_____
- □ You may send me an e-mail at:_____
- □ Other_____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____Date Added/Removed:_____
2. _____ Date Added/Removed:_____
3. _____ Date Added/Removed:_____
4. _____ Date Added/Removed:_____
5. _____ Date Added/Removed:_____

***

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgment
- □ An emergency situation prevented us from obtaining the acknowledgment
- □ Other (Please Specify)_____

Hope DENTAL PROFESSIONALS

2618 S.E. J Street #6
Bentonville, Arkansas 72712
479-254-8111

Understanding Your Dental Insurance

At Hope Dental Professionals, we strive to give the highest quality service. A part of that service is to help you understand how your insurance works and estimate your part of the investment in your dental health.

It is important that you know that we are here to **partner with you** in understanding your dental benefit to better help you maximize this benefit. In order to do this, we request you bring a copy of your insurance book, which you should have received when your benefit began. This will allow us to give you the best possible estimate and to better help you determine what exclusions and clauses are in your plan.

Some of the insurance companies we deal with do not always give information regarding their fees, and all of them do not guarantee benefit quotes (even with a predetermination). Your insurance plan is an agreement between you and the insurance company not between our office and the insurance company, so they are not obligated to our office to give information **Because of these practices, our estimates of your amount. As a service to you we allow a 45 day grace period for your insurance to pay before it becomes your responsibility.**

I have read the above information and understand the content.

Signature_____Date_____

I hereby authorize payment directly to the office of Hope Dental Professionals of the insurance benefit otherwise payable to me. I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance after 45 days regardless of my insurance, and that I am responsible for any attorney, collection and interest fees regarding collection of outstanding balances including1.5% / month or 18 %/ year interest if my balance goes past 90 days regardless of my insurance. Hope Dental Professionals is not a part of any court arrangement you may have for payment in regards to divorce, custody or other and the person signing below agrees to guarantee payment. I hereby authorize Hope Dental Professionals staff to administer such medications and perform such diagnostic, photographic (including X-Rays and study models) and therapeutic procedures as may be necessary for proper diagnosis and dental treatment. The information on these pages including but not limited to the dental and medical histories as well as general demographics are correct to my best knowledge. I grant the right to Hope Dental Professionals to release my Medical/dental histories and other information about dental treatment to third party payers and /or other health professionals.

Patient / Guardian Signature _____ **Date**_____

Informed Consent- General Consent for Treatment

I understand that all dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- **Drug reactions and side affects**
- **Damage to adjacent teeth or fillings**
- **Post-operative infection**
- **Post-operative bleeding that might require treatment**
- **Delayed healing of an extraction site, (dry Socket) necessitating additional care**
- **Sinus involvement during removal of upper molars which require additional treatment or surgical repair at a later date**
- **Involvement of nerves during removal of teeth resulting in temporary or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas**
- **Bruising, swelling, sensitivity or pain**
- **Failure of a dental procedure necessitating additional treatment**
- **Breakage of dental interments inside the tooth canals making additional treatment necessary**
- **Complications during treatment necessitating referral to a specialist**

I understand the recommended treatment for my condition(s), the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing. Any fees involved have also been explained. All of my questions have been answered, and I have not been offered any guarantees.

My signature also confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly**
- ❑ **Obtain payment from third-party payers for my health care services**
- ❑ **Conduct normal health care operations such as quality assessment and improvement activities**

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Printed Name_____

Patient/Guardian Signature_____**Date**_____

Witness_____**Date**_____

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