toothtales™

PATIENT INFORMATION

Please circle best means of contacting you: home phone / cell phone / email

Patient name: ..... Nickname: .....

Birthday: ..... Age: ..... Grade: ..... Sex: male / female

Names & age of brothers/sisters .....

School: ..... Child's learning: slow / average / accelerated

Child's interests: ..... Name of pets: .....

Does your child have any special needs? ..... Any phobias? .....

Whom may we thank for referring you to us? .....

What is the reason for your child's visit? .....

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name: ..... Relationship: ..... Phone: .....

Name: ..... Relationship: ..... Phone: .....

INSURANCE INFORMATION

Do you have dental insurance coverage for your child? Y / N

Insurance co.: ..... Group/policy #: .....

Policy owner name: .....

Insurance co. address: .....

Insurance co. phone #: ..... Relationship: .....

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in Dr. Chen's professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE: ..... Relationship: ..... date: .....

HEALTH HISTORY

Child's pediatrician: ..... Phone number: ..... Last physical: .....

Is your child under a physician's care now? Y / N if yes, reason: .....

Any hospitalizations or surgery? Y / N if yes, when and explain: .....

Is there excessive bleeding when cut? Y / N if yes, please explain: .....

Is your child currently taking any medications? Y / N if yes, please list: .....

Does your child have any allergies? Y / N if yes, please list: .....

Please check if your child has been treated for any of the following:

○ heart disease	○ blood transfusions	○ asthma	○ blood dyscrasias
○ liver/GI disease	○ anemia	○ diabetes	○ AIDS/HIV
○ kidney disease	○ rheumatic fever	○ depression/anxiety	○ mental delays
○ speech / hearing	○ seizures / epilepsy	○ premature birth	○ physical delays
○ cerebral palsy	○ congenital birth defects	○ emotional	○ thyroid disease
○ cancer / tumors	○ recurrent headaches	○ measles / mumps	○ drug / alcohol abuse
○ tuberculosis	○ fainting	○ TMJ problems	○ other
○ down's syndrome	○ eating disorders	○ chemo /radiation therapy	○

Please elaborate on any items checked: .....

toothtales™

GENERAL INFORMATION

Circle your relationship to the patient? mother / father / guardian / other

Your general dentist _____ Marital status: single / married / divorced / widowed

Father: _____ SSN: _____ Birthdate: _____ DL#: _____

Mother: _____ SSN: _____ Birthdate: _____ DL#: _____

Home phone: _____ cell phone: _____ email: _____

Home address: _____

street city, state zip code

Do you have legal custody of the child? Y / N

Person financially responsible for child's dental care: _____

DENTAL HISTORY

Is this your child's first dental visit? Y / N if no, previous dentist? _____

Date of last visit _____ How was his / her experience? _____

Child's attitude towards the dentist or dental treatment: _____

Has your child had any injuries to teeth, mouth or head? Y / N if yes, please describe: _____

Has your child done any of the following (past or present)? please circle

thumb/finger sucking pacifier nail biting tongue sucking mouth breathing

teeth grinding snoring nursing bottle-feeding

Is your water fluoridated? Y / N Does your child take fluoride supplements? Y / N

Does your child use fluoridated toothpaste? Y / N

How often does your child brush his/her teeth? _____ ...with adult supervision? Y / N

How often does he/she floss? _____

How can we help to make the visit a positive experience for your child? _____

FINANCIAL AGREEMENT

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for true dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $10.00 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained. Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your claim promptly. You will be required to pay your portion at the time of dental treatment.

For patients without insurance: Payment in full is expected at the time of dental treatment. When this is not possible, financial arrangements must be made in advance. I realize that failure to keep this account current may result in the dentist unable to provide additional true dental services except for dental emergencies or where there is prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $10.00 will be added to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained.

A special time is reserved for your child to allow quality time for your child, for missed dental treatment appointments (without at least a 24 hour notice) there will be a $35 charge.

SIGNATURE: _____ Relationship: _____ date: _____

toothtales™

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. I hereby consent to the use and disclosure of my health information for the purposes and the activities under the federal law. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the office at (954) 236 5273.

Patient's name (please print) Date

Signature (if minor Parent or Guardian)

Patient's Legal Representative

Signature of Legal Representative Date

FOR DENTAL OFFICE USE ONLY

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

- ◯ Individual refused to sign
- ◯ Communications barriers prohibited obtaining the ACKNOWLEDGEMENT
- ◯ An emergency situation prevented us from obtaining ACKNOWLEDGEMENT
- ◯ Other (please specify)

toothtales™

We appreciate you allowing us to provide dental care for your child. We value our relationship with you and believe that the best relationships are based on understanding and good communication; we offer these clarifications of our office policies

Parent Information

A parent is welcomed to accompany their child on their first visit to view our facilities and to personally meet the doctor and staff. For the safety and privacy of all patients, other children and family members who are not being treated must remain in the reception room with a supervised adult. Everyone will make a great effort to ensure that your child feels comfortable in these new surroundings. Since the first visit will establish their initial attitudes towards dentistry and our office, it is very important to make this appointment a positive encounter. If you choose to accompany your child at this initial visit we ask that you please remain in the designated parent area and play the role of silent and supportive observer unless otherwise asked. We know that the trust we have established with the parents and child at this initial visit will make for an easy transition when the child is unaccompanied for subsequent visits. This allows the child to establish an uninterrupted relationship with the doctor and the staff and enables them to gain confidence during dental treatment. If your child requires a treatment appointment you will be allowed to see your child in the quiet room but will be requested to stay outside of the doors. If, at any time during treatment, we feel the need for parental involvement, we will invite the parent in the room. Please no cell phones in patient areas.

Appointment Policy

If your child is under the age of 5 years old we request that you schedule a morning appointment. Younger children do better when they are well rested. Your scheduled appointment time has been reserved specifically for your child. We request 24 business hours notice if you need to cancel an appointment. We are aware that unforeseen events sometimes require missing an appointment. However, if you do miss an appointment without notifying us 24 hours in advance, a cancellation fee will be applied to your account. The cancellation fee will vary depending on the length of time and type of procedure reserved for you and your child.

Publications

From time to time we may display artwork, pictures and accomplishments of our patients. The purpose may be for contests within the office, for advertisement purposes or to display a great job they have done.

A special thanks from the Tooth Tales family!

We welcome any questions!

I have read and understand the Office Policies and agree to abide by its contents:

Parent/Guardian Signature _____ Date _____

toothtales™

PERMISSION FORM

I , _____ , the parent of _____
Parent's Name Child's Name

give DR. TIMOTHY CHEN & STAFF permission to treat my child while I am not present. The individual bringing my child to the appointment is named, _____ , the _____
Name of Individual Relationship to Child

of the child and is eighteen years or older of age. I also give this individual permission to make decisions regarding my child's dental treatment, medical treatment (if necessary should an emergency arise) and behavior management.

_____ _____
Signature Date

_____
Relationship to Patient

Copy of parent's driver's Licence: