Discovery Dental

Creating a generation that enjoys dental care

Health History

Child's Name: _____ **Date of Birth:**_____/_____/_____ ❑ M ❑ F

1. Is this your child's first dental visit? ❑ Yes ❑ No
2. Previous Dentist's Name?_____
3. Date of last visit (if known): _____
4. Has your child ever had a bad dental experience? ❑ Yes ❑ No
5. Is your child in pain? ❑ Yes ❑ No
6. Has your child been under the care of a medical doctor during the past 2 years **other than routine exams**? ❑ Yes ❑ No
7. Has your child ever been hospitalized? ❑ Yes ❑ No
   Reason? _____
8. Does your child take any **medication** regularly? ❑ Yes ❑ No
   If yes, please list: _____
9. Has your child ever had oral conscious sedation? ❑ Yes ❑ No
10. Has your child ever had general anesthesia? ❑ Yes ❑ No
    If yes, any complications? _____
11. Has your child ever had a reaction to anesthetic? ❑ Yes ❑ No

Name of Physician: _____ **Physician Phone:**_____ **Date of Last Physical:** ___/___/___

PLEASE CHECK "YES" OR "NO" TO THE FOLLOWING CONDITIONS

Y	N		Y	N		Y	N	
❑	❑	Drug Allergies:_____	❑	❑	Bleeding Disorders	❑	❑	Heart Surgery
❑	❑	Food Allergies:_____	❑	❑	Chemotherapy/Cancer	❑	❑	High/Low Blood Pressure
❑	❑	Latex Allergy	❑	❑	Cortisone Medicine	❑	❑	Kidney Failure/Dysfunction
❑	❑	ADHD/ADD	❑	❑	Diabetes	❑	❑	Liver Disease
❑	❑	Asthma:	❑	❑	Down Syndrome	❑	❑	Obstructive/Central Sleep Apnea
	❑	Seasonal	❑	❑	Epilepsy/Seizures	❑	❑	Psychiatric Treatment
	❑	Exercise Induced	❑	❑	Irregular Heart Beat	❑	❑	Rheumatic Fever
	❑	Ever Hospitalized:_____	❑	❑	Heart Defect/Disease	❑	❑	Sensory Processing Disorder
❑	❑	Autism	❑	❑	Heart Murmur	❑	❑	Thyroid Disease

List any other serious medical conditions: _____

Does your child have any allergies to any other medications or substances? If yes, please list: _____

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to the doctors and their staff to perform such treatments, services, medication, behavior management techniques, local anesthesia, and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

Parent/Legal Guardian Signature: _____ Date: _____/_____/_____

Doctor Signature: _____ Date: _____/_____/_____

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Patient Information

Child's Name: _____ **Date of Birth:** ____/____/____ ❑ M ❑ F
Child's Name: _____ **Date of Birth:** ____/____/____ ❑ M ❑ F
Child's Name: _____ **Date of Birth:** ____/____/____ ❑ M ❑ F

PARENT / LEGAL GUARDIAN

Name: _____
Relationship to Patient: _____
Date of Birth: ___/___/___
Phone Number: _____
Mailing Address: _____
City: _____ State: _____
Zip Code: _____
Email: _____

PARENT / LEGAL GUARDIAN

Name: _____
Relationship to Patient: _____
Date of Birth: ___/___/___
Phone Number: _____
Mailing Address: _____
City: _____ State: _____
Zip Code: _____
Email: _____

With whom does this child reside: _____

PRIMARY DENTAL INSURANCE

Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Social Security Number: _____
Relationship to Patient: _____
Name of Insurance Company: _____
Phone Number: _____
Group Number: _____ ID Number: _____

SECONDARY DENTAL INSURANCE

Subscriber Name: _____
Subscriber Date of Birth: _____
Subscriber Social Security Number: _____
Relationship to Patient: _____
Name of Insurance Company: _____
Phone Number: _____
Group Number: _____ ID Number: _____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name: _____ Phone Number: _____
Relationship to Patient: _____

How did you hear about our office? ❑ Patient ❑Sign ❑ Website ❑ Radio ❑ Magazine
❑ Facebook ❑ Dr./Pediatrician _____
❑ Other _____

Discovery Dental



Financial Policy

Child's/Children's Name(s): _____

Regarding Insurance:

Discovery Dental realizes how important insurance benefits are. We ask that you carefully review your policy and/or contact your insurance so that you are aware of your benefits and frequencies, limitations and/or restrictions. Please be informed that dental insurance is a contract between you and your insurance company, as a courtesy we will assist you with filing your insurance claim(s). Your dentist is providing the highest quality of care regardless of insurance frequencies, limitations and/or restrictions. Please be aware that your insurance may have a yearly maximum and anything over that will be your responsibility. If any dental services have been provided for you by another provider within your benefit year those fees will count toward your maximum as well. If you have two insurance policies, please be aware that not all policies will cover remaining portions after your first insurance has paid. Please provide Discovery Dental with your insurance card(s) at the time of your appointment and notify us of any dental coverage change and/or new policy. It is your responsibility to provide us with any future changes with your insurance. By initialing here I acknowledge that I have read and understand this.

Financial Agreement:

In order to provide you with the highest quality dental care on a sound business basis, we provide our patients with estimates of fees as a courtesy. Remember that there is always a possibility that your insurance may not pay the estimated amount and that as a patient, parent and/or guardian you are responsible for your balance. Its is your responsibility to call your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility, and interest will be applied to your account. Financial options that we provide at this time are: Cash, Check, Major Credit Cards (Visa, MasterCard, American Express, and Discover), and Care Credit. Should collections become necessary, it is the patient, parent, and/or guardian's responsibility to pay all collection agency fees.

Appointment Commitment:

We appreciate you choosing us to serve your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time.
*If circumstances occur and it's necessary for you to change your scheduled appointment, we request that you give us at least 2 business days notice.

_____ ___/___/_____

Parent/Legal Guardian Signature Date