ACCOUNT# ____________
DR: ____________

MINOR CHILD PATIENT INFORMATION

NAME: ____________ ____________ ____________ PHONE#: ____________
FIRST LAST MIDDLE CELL HOME
ADDRESS: ____________ ____________ ____________ ____________
CITY STATE ZIP
SS#: ____________ BIRTHDATE: ____________ SCHOOL: ____________

GENDER: MALE FEMALE

EMERGENCY CONTACT: ____________ PHONE#: ____________

MOTHER'S INFORMATION

NAME: ____________ ____________ ____________ PHONE#: ____________
FIRST LAST MIDDLE CHOOSE ONE: CELL HOME
ADDRESS: ____________ ____________ ____________ ____________
CITY STATE ZIP
SS#: ____________ BIRTHDATE: ____________ ALT PHONE:: ____________
CHOOSE ONE: CELL HOME
EMAIL: ____________
EMPLOYER: ____________ POSITION: ____________ WORK #: ____________

FATHER'S INFORMATION

NAME: ____________ ____________ ____________ PHONE#: ____________
FIRST LAST MIDDLE CHOOSE ONE: CELL HOME
ADDRESS: ____________ ____________ ____________ ____________
CITY STATE ZIP
SS#: ____________ BIRTHDATE: ____________ ALT PHONE:: ____________
CHOOSE ONE: CELL HOME
EMAIL: ____________
EMPLOYER: ____________ POSITION: ____________ WORK #: ____________

PRIMARY DENTAL INSURANCE INFORMATION

EMPLOYEE: ____________ ____________ ____________ BIRTHDATE: ____________
FIRST LAST MIDDLE
SS#: ____________ RELATIONSHIP TO PATIENT ____________
EMPLOYER: ____________ INSURANCE NAME: ____________
INSURANCE ID#: ____________ GROUP#: ____________ PHONE# ____________

SECONDARY DENTAL INSURANCE INFORMATION

EMPLOYEE: ____________ ____________ ____________ BIRTHDATE: ____________
FIRST LAST MIDDLE
SS#: ____________ RELATIONSHIP TO PATIENT ____________
EMPLOYER: ____________ INSURANCE NAME: ____________
INSURANCE ID#: ____________ GROUP#: ____________ PHONE# ____________

PLEASE SEE BACK OF THIS PAGE

TO BETTER SERVE YOU AND TO OFFER YOU THE BEST CARE POSSIBLE, PLEASE READ THE FOLLOWING:

OFFICE POLICIES

Payment is due in full at time of service. If you have insurance, we will bill it as a courtesy to you. Your deductible and co-pay will be due at time of service. Payment can be made by cash, check or credit card.
If your balance remains unpaid past 90 days from the date of service a late fee will be charged:
$15.00 for balances between $15.00 and $199.00
$29.00 for balances over $200.00 will be applied.
If your account is sent to a collection agency for non-payment a **25% administrative fee** is added to the principle balance, including any late charges.

INSURANCE

As a courtesy to you we will file your insurance claims, to help you receive maximum benefits. To do so we will require a copy of your insurance card and ID. Insurance is a contract between you and your insurance company; we are not a responsible party to this contract. We will do whatever we can to help you receive benefits from your insurance carrier, but we are unable to get involved in disputes concerning; covered charges, co-payments, usual and customary charges, etc. We try our best to let you know what your co-payment for treatment will be, however, any quote you are given is only an ***estimate of your treatment and your insurance benefits***. To continue to offer you competitive fees if your insurance does not cover the expected amount, denies the service, or has not paid within 60 days of your service date, you are responsible for paying your balance in full.

CANCELLATION POLICY

Please give 48 hours notice to cancel an appointment, this allows us time to offer the appointment to another patient. ***In the event of a cancelled appointment with less then 24 hours noticed or a missed appointment, there will be a $50.00 charge.*** Our recorder is monitored before and after hours so please let us know as soon as possible if you must change an appointment.

MINOR CHILDREN

Children under the age of 18 will need to be accompanied to their appointment by a parent or legal guardian.

If you plan to leave during treatment of the minor child please discuss treatment with the hygienist or doctor prior to leaving, and be available to answer questions if a problem arises **If you fail to do this, we will do treatment as necessary**. Occasionally, treatment may change, if you are unavailable we will treat your child with what we deem is appropriate care. As an example, bitewings x-rays are routinely taken once a year during the exam appointment, if you choose not to have these taken then you would need to speak directly to the dentist, dental assistant, or hygienist who is treating your child.

HEALTH INFORMATION RELEASE AND INSURANCE ASSIGNMENT FOR THE ABOVE MINOR CHILD:
I hereby authorize and give my full consent to Huffman Family Dentistry, LLC, for use and disclosure of myself and my childs personal and protected health information to carry out dental treatment, payment activities, any and all necessary internal healthcare operations. I assign to the doctors all payments for dental treatment rendered to dependents or myself. I understand that I am responsible for any amount not covered by insurance. I may revoke this in writing at any time.

Please read our, "NOTICE OF PRIVACY STATEMENT" ON OUR WEB PAGE, IN OUR OFFICE OR REQUEST ONE TO BE SENT TO YOU.
I HAVE READ AND UNDERSTAND THE ABOVE PROCEDURES AND POLICIES.

PRINT NAME:______________________________________ DATE:__________________

SIGNATURE:______________________________ RELATIONSHIP TO PATIENT:______________
I AM LEGALLY AUTHORIZED TO MAKE MEDICAL DECISIONS FOR THE ABOVE CHILD

PATIENT MEDICAL HISTORY

NAME______________________________ DATE______________

DATE OF BIRTH ______________________________

PHYSICIAN______________________________

APPROXIMATE DATE OF LAST PHYSICAL EXAMINATION ______________________________

PLEASE LIST ANY CURRENT MEDICAL TREATMENT? ______________________________

HAVE YOU HAD ANY MAJOR OPERATIONS IN THE LAST THREE YEARS?______________________________

HAVE YOU EVER HAD ANY ADVERSE RESPONSE TO ANY DRUGS INCLUDING PENICILLIN?______________________________

HAVE YOU EVER BEEN DIAGNOSED WITH ANY OF THE FOLLOWING? PLEASE CIRCLE: YES OR NO

HIGH BLOOD PRESSURE	YES NO	RHEUMATISM OR ARTHRITIS	YES NO	LUPUS	YES NO
A HEART AILMENT	YES NO	HIP OR KNEE REPLACEMENT	YES NO	CANCER	YES NO
RESPIRATORY DISEASE	YES NO	AUTOIMMUNE DISEASE	YES NO	DIABETES	YES NO
RHEUMATIC FEVER	YES NO	ANY LIVER DISEASE	YES NO	VENEREAL DISEASE	YES NO
HEART MURMUR	YES NO	ANY KIDNEY DISEASE	YES NO	A BLOOD DISEASE	YES NO
TUMORS OR GROWTHS	YES NO	HEPATITIS OR JAUNDICE	YES NO	AIDS	YES NO
USE OF PHEN PHEN	YES NO	MITRAL VALVE PROLAPSE	YES NO	HIV POSITIVE	YES NO

ANY OTHER MEDICAL CONDITION NOT LISTED______________________________

ARE YOU ALLERGIC TO LATEX?.. YES NO

DO YOU HAVE NIGHT SWEATS ACCOMPANIED BY WEIGHT LOSS OR COUGH?.............................. YES NO

ARE YOU ON A DIET AT THIS TIME?.. YES NO

HAVE YOU EVER HAD AN ALLERGIC REACTION RESULTING IN HIVES, ASTHMA, ECZEMA, ETC.? YES NO

DO YOU HAVE ANY HEALTH CONCERNS?.. YES NO

HAVE ANY WOUNDS HEALED SLOWLY OR PRESENTED OTHER COMPLICATIONS?.......................... YES NO

HAVE YOU EVER HAD ANY X-RAY TREATMENT'S (OTHER THAN DIAGNOSTIC)?.......................... YES NO

ARE YOU TAKING ANY MEDICATIONS AT THIS TIME?.. YES NO

IF YES PLEASE EXPLAIN______________________________

ARE YOU PREGNANT? YES NO DUE DATE?____________ DR.'S NAME ______________________________

PATIENT DENTAL HISTORY

DO YOU HAVE PAIN IN OR NEAR YOUR EARS.. YES NO

DOES ANY PART OF YOUR MOUTH HURT WHEN CLENCHED.. YES NO

HAVE YOU EVER HAD A REACTION TO ANESTHETIC ORAL OR OTHERWISE?.................... YES NO

IF SO PLEASE EXPLAIN______________________________

HAVE YOU EVER HAD ANY DIFFICULTY WITH EXTRACTION'S?.. YES NO

HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING EXTRACTION'S IN THE PAST?.. YES NO

DO YOU HAVE ANY UNHEALED GROWTH OR SORE SPOT IN YOUR MOUTH...................... YES NO

IS ANY PART OF YOUR MOUTH SENSITIVE TO PRESSURE, HOT COLD OR SWEETS?......... YES NO

DO YOUR GUMS BLEED?.. YES NO

ARE YOU CONCERNED ABOUT BAD BREATH?.. YES NO

DO YOU CLENCH OR GRIND YOUR TEETH?.. YES NO

DOES YOUR FACE HURT?.. YES NO

DO YOU CHEW ON ONE SIDE OF YOUR MOUTH?.. YES NO

HAVE YOU EVER HAD A FULL MOUTH OR PANORAMIC X-RAY TAKEN? WHEN?................ YES NO

IF THERE WAS A CONVENIENT WAY TO WHITEN YOUR TEETH WOULD YOU BE INTERESTED? YES NO

IF YOU COULD, WOULD YOU CHANGE YOUR SMILE?.. YES NO

DO YOU SMOKE OR CHEW TOBACCO?.. YES NO

HAVE YOU HAD PREVIOUS PERIODONTAL SURGERY? WHERE?______________ WHEN?______________

SIGNATURE ______________________________ DATE ______________