YOUR CHILD'S DENTAL HISTORY AND HABITS

Your Child's Name _____ **Nickname** _____ **Date** _____

Welcome! *So that we may provide your child with the best possible care, please complete both sides of this dental/medical history form. All information is completely confidential. Please be sure to answer individually any yes or no questions.*

What is the reason for your visit today? _____

_____

Your Child's Previous Dentist: Name _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Date of your child's last dental visit _____ Last dental cleaning _____ Last full mouth x-rays _____

How often does your child brush? _____ Floss? _____ Do you assist? □ Yes □ No

Is your child's water fluoridated? □ Yes □ No Does your child take fluoride supplements? □ Yes □ No

Does your child have any dental problems now? □ Yes □ No If yes please describe _____

_____

Has your child had difficulty with previous dental visits? □ Yes □ No If yes please describe _____

Has your child complained about dental problems? □ Yes □ No If yes please describe _____

Has your child ever worn orthodontic appliances? □ Yes □ No If yes please describe _____

Are any of your child's teeth sensitive to:

Hot or cold?……□ Yes □ No Sweets? …… □ Yes □ No Biting or Chewing?…… □ Yes □ No

Does your child engage in:

Sucking thumb or fingers?	□ Yes	□ No	Chewing or biting fingernails?	□ Yes	□ No
Biting or sucking lips or cheeks?	□ Yes	□ No	Chew hard objects (e.g. pencils)	□ Yes	□ No
Grinding teeth?	□ Yes	□ No	Clenching jaw?	□ Yes	□ No
Mouth breathing?	□ Yes	□ No	Nursing bottle or pacifier habits?	□ Yes	□ No

Does your child's gums bleed or hurt?…… □ Yes □ No

Does your child have any pain or tenderness in the jaw joint, ear, side of face?… □ Yes □ No

Do you have any special concerns about your child's dental health? …… □ Yes □ No

If yes, please describe _____

_____

_____

YOUR CHILD'S MEDICAL HISTORY

Date _____

Birth Date _____ **Patient Account Number** _____ **Medical Alert** _____

Your Child's Physician: Name _____ Telephone_____

Address _____ City _____ State _____ Zip _____

Is your child under the care of a physician? ..... □ Yes □ No
If yes, please describe _____

Is your child taking any medications? (prescription or over-the-counter) ..... □ Yes □ No
If yes, please describe _____

Have you ever been told your child needs antibiotics or premeds before treatment..... □ Yes □ No

Does your child have any allergic (or adverse) reaction to any medication or other substance? .....□ Yes □ No
If yes, please list _____

Are your child's immunizations current? ....□ Yes □ No

List any Hospitalizations, Surgeries, Serious Illnesses **When?**

_____ _____
_____ _____
_____ _____

Indicate which of the conditions your child has now or ever has had. Mark each answer individually.

Abnormal bleeding	□ Yes □ No	Diabetes	□ Yes □ No	Latex sensitivity	□ Yes □ No
AIDS/HIV positive	□ Yes □ No	Epilepsy	□ Yes □ No	Measles	□ Yes □ No
Allergies or hives	□ Yes □ No	Handicaps/disabilities	□ Yes □ No	Mononucleosis	□ Yes □ No
Anemia	□ Yes □ No	Hay fever	□ Yes □ No	Mumps	□ Yes □ No
Asthma	□ Yes □ No	Hearing problems	□ Yes □ No	Neurological disorders	□ Yes □ No
Cancer	□ Yes □ No	Heart murmur	□ Yes □ No	Psychiatric/psychological	□ Yes □ No
Chicken Pox	□ Yes □ No	Hemophilia	□ Yes □ No	Rheumatic/scarlet fever	□ Yes □ No
Congential heart	□ Yes □ No	Hepatitis	□ Yes □ No	Stomach problems	□ Yes □ No
Convulsions	□ Yes □ No	Kidney/liver problems	□ Yes □ No	Tuberculosis	□ Yes □ No

Other? ..... □ Yes □ No Please specify _____
_____

I understand that the above information is necessary to provide my child with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

Signature of Parent/Guardian _____ Date _____

Dentist's Review

Dentist's Signature _____ Date _____

COHIL FAMILY DENTISTRY
FAMILY, COSMETIC, AND RESTORATIVE DENTISTRY

OFFICE POLICIES AND GOALS

Our Financial Policy

Thank you for choosing us to serve your dental health needs. We are committed to your treatment being successful. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to your treatment. All patients must complete the Patient Information form, HIPPA, and the Office Policies and Goals form.

- Full payment (or the "estimated patient portion", if insured) is due at time of service
- We accept cash, debit, and credit cards.
- We do offer an extended payment plan with prior credit approval
- You are responsible for your account with the office (regardless of whether insurance is involved). This includes updating insurance information when it has changed.

Regarding Insurance

We consider our fees to be a matter between you and our office, regardless of insurance coverage. Rarely does an insurance plan cover all expenses involved in treatment other than preventative care, which is usually (but not always) covered at 100%. (Sometimes there is a deductible involved for preventative care). We take pride in doing everything possible to help our patients utilize and maximize their insurance benefits. We file insurance as a courtesy to our patients. Please understand that every effort is made to let you know what your estimated portion may be from your insurance company. We also will provide you with what your estimated financial responsibility for that visit will be. We do expect your estimated portion paid on day of service. All benefits are estimated and are not a guarantee for payment. The insurance policy is a contract between you and your insurance company. We are not party to that contract. Our office allows 60 days for benefits to be received in this office from the day of treatment. After that time, you are expected to reconcile your balance immediately. Again, we do everything possible to assist the insurance company to make benefit payment in a timely manner. To keep you informed of processing your claim, the insurance company should send you a copy of the "explanation of benefits". This is printed on the insurance form after treatment is performed.

Missed Appointments

Each of your scheduled appointments is a designated time that has been "*reserved*" just for you! We respect your time and ask that our patients in turn, do the same for us. If you should find that your appointment needs to be changed, a 24 hour notice is required. A cancellation fee of $50 will be charged to those not fulfilling this requirement. Please help us serve you better by keeping your scheduled appointment(s).

Minors

The adult accompanying a minor and the parent(s) or guardian is responsible for full payment (estimated portion due, if insured). For unaccompanied minors, payment arrangements must be made in advance with payment accompanying the minor the day of treatment. Thank you for understanding our financial policies and goals for service to our patients. We thank you for choosing us to serve your dental health needs! Please let us know if you have any questions or concerns.

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I further understand that a finance, rebilling, collection charge and/or attorney fees will be added to any overdue balance. In the event there is a dispute, the prevailing party, is awarded any and all attorney and collection fees. The information on this page and the dental/ medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

X_____

☐ Adult ☐ Father (or husband) ☐ Mother (or wife) ☐ Guardian

Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient | Legal Relationship to the Patient *(If required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

Consent to email or text for appointment reminders and other healthcare communication.

If you approve, we may contact you via email and/or text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text or email, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

The email address that I authorize to receive email messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ **I decline** to receive communications via **text**.

_____ **I decline** to receive communications via **email**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.
_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via email.

Patient signature_____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible

Kirk K. Cohil, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

FOR OFFICE USE ONLY

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

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature *Date*

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE: ____MINOR ____SINGLE ____MARRIED ____DIVORCED ____WIDOWED ____SEPARATED

IF COLLEGE STUDENT: F.T./P.T. NAME OF SCHOOL _____ CITY _____ STATE _____

PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____ EXT _____

BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK # _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ STATE _____ ZIP _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____ EXT _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? _____YES _____NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____ EXT _____

EMPLOYER ADDRESS _____ CITY _____ STATE ____ ZIP _____

INSURANCE CO. _____ PHONE # _____ GROUP # _____ POLICY/ID # _____

INSURANCE CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ___YES ___NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ WORK PHONE _____ EXT _____

EMPLOYER ADDRESS _____ CITY _____ STATE ____ ZIP _____

INSURANCE CO. _____ PHONE # _____ GROUP # _____ POLICY/ID # _____

INSURANCE CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

X _____ SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR