Patient Introductory Profile

To help us better serve you, if you're a new patient or if this is your child's first visit to our office, please fill out your New Patient Paperwork. Please *fill out all required fields* or your New Patient Paperwork will not be submitted successfully. Thank you for choosing VIP Pediatric Dentist as your pediatric dental provider!

Today's Date: ________________

Patient Information:

First Name: __________________ Middle Initial: ___________________

Last Name: __________________________ Date of Birth: ________________

Gender: Male Female Undecided Other

Child Social Security Number ____________________

Parent/Legal Guardian Phone: ____________________

Home Address: ____

City: _____________________ State: ________________ Zip code: _______________

Ethnicity: (Check all that apply)

- American Indian or Alaska Native
- Asian
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Prefer not to answer

How did you hear about us? (Check all that apply)

- Social media
- Google
- Insurance Directory
- School
- Friend, please provide name: ________________________
- Family Member, please provide name: ___________________

Parent, Foster Parent, or Legal Guardian Information

Parent/Guardian 1:

First Name: ___________________________ Middle Initial: ____________________

Last Name: ____________________________ Date of Birth: _________________

Relationship to Patient: ___________________

Parent/Guardian Social Security Number _____________________

Parent/Guardian Email Address: _____________________________________

Home Address (If different than Childs): ____

City: ______________________ State: _________________ Zip code: ________________

Parent/Guardian 2: (if applicable)

First Name: ___________________________ Middle Initial: ____________________

Last Name: ____________________________ Date of Birth: _________________

Relationship to Patient: ___________________

Parent/Guardian Social Security Number _____________________

Parent/Guardian Email Address: _____________________________________

Home Address (If different than Childs): ____

City: ______________________ State: _________________ Zip code: ________________

Insurance & Payment Information

My child's dental visit will be covered by: (please check all that apply)

Insurance Carrier

Self paid/out of pocket

Primary Dental Insurance

Insurance Company Name: ________________________________

Main Policy Holder information:

First Name: ___________________________ Middle Initial: ____________________

Last Name: ____________________________ Date of Birth: _________________

Home Address (If different than Childs): ____

City: ______________________ State: _________________ Zip code: ________________

Relationship to patient: _______________________

Subscriber I.D or Social security number: _______________________

Employer/Group name: _________________________

Group number: ______________________

Secondary Dental Insurance (if applicable)

Insurance Company Name: ________________________________

Main Policy Holder information:

First Name: ___________________________ Middle Initial: ____________________

Last Name: ____________________________ Date of Birth: _________________

Home Address (If different than Childs): ____

City: ______________________ State: _________________ Zip code: ________________

Relationship to patient: _______________________

Subscriber I.D or Social security number: _______________________

Employer/Group name: _________________________

Group number: ______________________

Fluoride Consent

Most insurance companies cover fluoride treatment twice a year; however, some insurance companies only pay for a once-a-year application.

Please choose and check one of the Following:

I give my consent to apply fluoride treatment TWICE a year. I agree that if the insurance company does not pay for the second application, that I am financially responsible for payment.

I give my consent to apply fluoride only once a year.

I do not wish fluoride treatment to be applied on my child at any time.

Financial Arrangements & Insurance Agreement

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

Any unpaid balance due (as listed on a billing statement), not paid within 28 days of the monthly billing date, will be assessed a late charge of 1.5% each month. I realize that failure to keep this account current may result in my children being unable to receive additional dental services except for dental emergencies or when there is pre-payment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection cost (33% of the unpaid balance), postage, attorney and court fees incurred in attempting to collect on this amount or any future outstanding balances.
I hereby authorize the office to contact the designated phone numbers and/or email address listed in the patient's account. With this authorization, a message/communication may be left indicating appointment time and dates, reminders, balances due, and/or estimated co-pays for future visits.

Financially responsible for the account:

Self

Other: __________

Is the child in foster care? Yes No

Parent/Guardian Signature: ______________________ **Date**: ________________

Acknowledgement of HIPAA Privacy Practices

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You also consent to having been provided with access to a copy of the company's Notice of Privacy Practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters regarding your protected health information and your patient rights under HIPAA. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time from the dental office, our website.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat your child if you revoke this consent.
I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patients Full Name: ______________________________

Parent/Guardians Full Name (printed): ________________________________

Parent/Guardian Signature: ______________________________ Date: _________________________________

Child's Medical History

Name of Primary care Doctor (if applicable): ___________________________

City: _________________________ Phone Number: ____________________

Is your child presently under the care of a physician for any medical issue?

Yes

No

If yes please specify: ____________________________________

Has your child had any history of the following? Please check those that apply:

□ Heart Murmurs
□ Allergies
____
____
□ Heart Trouble
□ Allergy to anesthesia
□ Drug sensitivity
□ High Temperature
□ Brain injury/ Concussion
□ Vision Problems
□ Premature Birth
□ Diabetes

□ Asthma
□ Epilepsy
□ Seizures/Convulsions
□ Recurrent Headaches
□ Fractured Jaw
□ Lung problems
□ Artificial Prosthesis
□ Congenital birth defects
□ Hearing impairment
□ Speech problem
□ Anemia
□ ADD/ADHD

□ Autism/Asperger's
□ AIDS/ARC/HIV
□ Kidney/Liver Involvement
□ Nervous System Issues
□ Cancer/Tumors
□ Pregnancy
Due date: ___________
□ Radiation Treatment
□ Leukemia
□ Hepatitis
□ Bleeding problems
□ Blood disorders

□ High Blood pressure
□ History of blood transfusion
CURRENT MEDICATIONS:
□ ____________________
□ ____________________

Has your child had any complications following dental treatment? □ Yes □ No

If yes, please explain:

____

Has your child ever been admitted to a hospital or needed emergency care during the past two years? □ Yes □ No

If yes, please explain:

____

Do you have any health problems that need further clarification? □ Yes □ No

If yes, please explain:

____

Is there anything else regarding your child's mental and emotional health we should know?

If yes, please explain:

____

Parent/Guardian Signature: _______________________ Date: ________________

Dental History/
Preventative Dental History

Reason for scheduling dental appointment?

____.

Is this your child's first visit to the Dentist?

Yes No

Any previous or recent injury to your child teeth or jaws? (Falls, blows, chips, etc.)

Yes No

If yes please specify.

____.

What age was your child when they discontinued bottle nursing?

____.

How often does your child brush?

____.

Has your child experienced any unfavorable reaction
from previous medical or dental care?

Yes No

Is tooth brushing supervised?

____.

Is dental floss used?

Yes No

Does your child receive:

Fluoride vitamins
Fluoride Tablets/Drops
Fluoride water
None