Worman & Worman

Pediatric Dentistry

PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

Date _____

Patient's Name _____ Nickname _____

Age _____ Date of Birth _____ Sex _____ Race _____ School _____ Grade _____

Parents or Responsible Guardian _____ Tel.: Parent 1 Cell _____ Parent 2 Cell _____

Address _____
Number and Street City State Zip

Name of Child's Physician _____ Date last seen _____

Address _____ Telephone _____

Siblings (List by name and age please)

_____ _____

_____ _____

_____ _____

Parent 1 Name _____ Parent 2 Name _____

Home Address _____ Home Address _____

SSN _____ DOB _____ SSN _____ DOB _____

Parent 1 Occupation _____ Parent 2 Occupation _____

Parent 1 Employer _____ Parent 2 Employer _____

Parent 1 Email _____ Parent 2 Email _____

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

1. Is your child covered by a dental insurance plan? ☐ Yes ☐ No
   Name of parent insured _____ Social Security No. _____
   Name of Insurance _____ Group No. or Policy No. _____
   Has your child received previous dental care under this plan? ☐ Yes ☐ No
2. How did you first hear about our practice? _____
3. Is your child in pain, or have an emergency dental condition? ☐ Yes ☐ No
   If no, reason for bringing child to the dentist at this time _____

HISTORY	Yes	No
1. Is your child in good health?	☐	☐
If No, what is the reason? _____		
2. Is your child being treated by a physician at this time?	☐	☐
If Yes, why _____		
3. Has your child ever been a patient in a hospital?	☐	☐
If Yes, why _____		
4. Has your child ever received general anesthesia or sedation?	☐	☐
If Yes, why _____		
5. Is your child allergic to anything? (medicine, food)	☐	☐
If Yes, what _____		
6. Is your child taking any medication at this time?	☐	☐
If Yes, what _____	☐	☐
7. Has your child ever had a blood transfusion?	☐	☐
8. Has your child ever been seen by a dentist before?	☐	☐
Date last seen _____ Name of dentist _____		
9. Has your child ever received fluoride in any form?	☐	☐
10. Does your child suck his/her thumb or fingers?	☐	☐
11. Are your child's teeth brushed and flossed once or more a day?	☐	☐
12. Has your child had any unfavorable medical or dental experience?	☐	☐
If Yes, please explain _____		

REVIEWER COMMENTS

ORGAN SYSTEMS

Has this child ever had any treatment of any of the following? Please check Yes or No

Yes	No		Yes	No		Yes	No	
☐	☐	Blood - Circulatory	☐	☐	Gastrointestinal (stomach)	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Hearing	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Tonsils/Adenoids

ILLNESS

Has this child ever been diagnosed as having any of the following conditions? Please check Yes or No and explain below in comments section.

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Eye Problems	☐	☐	Polio
☐	☐	Anemia	☐	☐	Excessive Bleeding Problem	☐	☐	Pregnancy
☐	☐	Allergy	☐	☐	Fainting	☐	☐	Psychiatric Disorder
☐	☐	Arthritis	☐	☐	Hearing Loss	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Scarlet Fever
☐	☐	Autism	☐	☐	Hemophilia	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Hepatitis - Type_____	☐	☐	Sickle Cell Anemia
☐	☐	Bronchitis	☐	☐	HIV	☐	☐	Sinus Problems
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Snoring at Night
☐	☐	Cerebral Palsy	☐	☐	Leukemia	☐	☐	Sore Throats - Frequent
☐	☐	Chicken Pox	☐	☐	Measles	☐	☐	Speech Problems
☐	☐	Cleft Lip/Palate	☐	☐	Mental Retardation	☐	☐	Spina Bifida
☐	☐	Convulsions/Seizures	☐	☐	Mumps	☐	☐	Syndrome_____
☐	☐	Diabetes	☐	☐	Mouth Breathing	☐	☐	Tetanus
☐	☐	Diphtheria	☐	☐	Nutritional Deficiency	☐	☐	Tuberculosis
☐	☐	Drug or Alcohol Abuse	☐	☐	Orthopedic Problems	☐	☐	Tumors
☐	☐	Epilepsy	☐	☐	Pneumonia	☐	☐	Venereal Disease
						☐	☐	Whooping Cough
Is your child current on all vaccines? ☐ Yes ☐ No						☐	☐	Other _____

Is there anything else that you think we should know about your child? (Disabilities or Handicaps) _____

_____

I certify that I have read and understand the above questions. I will not hold Dr. Sandra Worman, or any member of her staff responsible for any errors or omissions I may have made in the completion of this form.

Because your child is a minor, it is necessary that we have signed permission from a parent/guardian for any and/or all necessary dental services. Your signature below indicates permission granted.

COMMITMENT POLICY

COMMITMENT TO APPOINTMENT POLICY:

We reserve time for each patient in our practice. An appointment put in our schedule with your name in it is a bond of trust that we will be here to serve you and you will be present for that appointment Therefore, our office policy in this regard is extremely firm and inflexible. You must be present for all scheduled appointments. We do no allow cancellations or constant short-notice changes. We charge for all cancellations made less than 48 hours in advance. (We do not accept recorded messages as appointment cancellations or changes). Your signature indicates that we must have mutual respect for each other's time.

COMMITMENT TO FINANCIAL AGREEMENT:

We believe we have a responsibility to use our best professional care, skill and judgment in planning for your dental treatment. Payment is expected at the time services are rendered, unless other financial arrangements were made. We work with most insurance companies to secure benefits. Insurance companies have different benefits available to which you are entitled according to the plan you chose. Should the account become delinquent and turned over to a collection agency, you are responsible for the balance and all collection fees.

Signature of Parent/Guardian	Relationship to patient	Date

COMMENTS _____

Michael A. Worman, D.D.S., P.A.
Sandra A Worman, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

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

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgment

___ Other (Please Specify)

Worman and Worman
Dentistry for Children

We reserve time for each patient in our practice. Please arrive promptly for all scheduled appointments. Lateness of more than10 minutes will necessitate a rescheduling of the appointment (s). All cancellations and rescheduling appointments require 48 business hours notice. Should you cancel an appointment with less than 48 business hours notice, it will constitute a broken appointment and a $50.00 fee will be assessed per child. We adhere strictly to this policy.

All co-pays are due and payable at the time service, so please be aware of your insurance benefits. Should the account become delinquent and turned over to a collection agency, you will be responsible for the balance and all legal and collection fees.

Divorced Parents: It is the policy of the office that the parent accompanying the child for treatment will be held responsible for all bills. We can not bill the other parent.

We gladly accept cash, personal checks and all major credit cards for payment. In the event you have a check returned, the return fee is $35.00. The original check amount *plus* the $35.00 fee are due in the form of a cash payment only. All further appointments will then be cash or credit card only.

Signature:_____

Date:_____