dental partners of Vero Beach

Comprehensive Dentistry
Airway Orthodontics
& Sleep Solutions
For Patients of All Ages

Child New Patient Information and Health History

Today's Date _____

New Patient Information

Child's Name _____ _____ _____
Last First Preferred Name

Birthdate _____/_____/_____ Age_____ Gender ❑ Male ❑ Female SS#_____

Home Address _____

City _____ State_____ Zip _____

School _____

How Did You Hear About Us?

❑ Family/Friend ❑ Google/Search ❑ Physician
❑ Social Media ❑ Advertisement ❑ Dawson
❑ Reviews ❑ Healthystart ❑ Other_____
❑ Referral/Who may we thank for referring your child? _____

Primary/Secondary Parent, Financially Responsible

#1- Name _____ Relationship to Patient _____
Best Contact Number _____ Alternative Number _____
Email _____ Date of Birth _____
What is your appointment confirmation preference (check all that apply) ❑ Text ❑ Phone ❑ Email

#2- Name _____ Relationship to Patient_____
Best Contact Number _____ Alternative Number _____
Email _____ Date of Birth _____
What is your appointment confirmation preference (check all that apply) ❑ Text ❑ Phone ❑ Email

Insurance Information, Subscribers Info ❑ Not Applicable

Subscribers Name_____ Subscribers Birthdate _____/_____/_____
Subscribers Phone #_____ Subscribers SSN # _____
Patient Relationship to Subscriber _____

Primary Dental Insurance
Insurance Co. Name _____
Member ID #_____
Group # _____
Customer Service Phone #_____

Secondary Dental Insurance (if applicable)
Insurance Co. Name _____
Member ID #_____
Group # _____
Customer Service Phone #_____

By signing this section, I understand that I am seeing an **OUT-OF-NETWORK PROVIDER** and I will be financially responsible for all charges not covered/denied by my insurance. I understand that Dental Partners of Vero Beach is not a Medicaid or Medicare provider and I will assume all financial responsibility for any services rendered. I authorize my insurance company to pay Dental Partners of Vero Beach all insurance benefits rendered. I authorize Dental Partners of Vero Beach to release all information necessary to secure the payment of benefits.

Signature: _____ Date: _____

Patient Name _____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients/representative for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash/check/credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services are charged directly to the insurance company and or responsible party of the patient and that the patients responsible party is personally responsible for any balance the insurance does not cover. This office will prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. This dental office cannot render services on the assumption that our charges will be paid by insurance.

I understand that the fee estimates for dental care can only be extended for a period of 90 days from the date of the patient examination/consultation.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my child's treatment.

I understand the above information and agree to its contents.
Signature: _____

Accompanying Your Child

A parent or legal guardian must be present during appointments. Please list any person(s), other than legal parents/ guardians, who are authorized to accompany your child to any routine dental visits

Name_____ Relation_____

Name_____ Relation_____
Authorized person(s) must present ID upon arrival ❑ None; only legal parents/guardians may accompany

Dental History

Please tell us the reason for today's visit. ❑ First visit to dentist ❑ Change of dental provider ❑ Emergency
❑ Other _____
If not the first visit, when did they see a dentist prior? Date _____
Dentist _____ Address_____
Were X-Rays taken? ❑ Yes ❑ No
Have there been any injuries to the teeth, face, or mouth? ❑ Yes ❑ No If yes, please explain
_____

Has your child had any pain or tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does your child have any of the following habits/concerns?

❑ Thumb/Finger Sucking ❑ Mouth Breathing ❑ Tooth Grinding ❑ Lip Sucking/Biting
❑ Nursing/Bottle Habits ❑ Nail Biting ❑ Pacifier Use ❑ Snoring
❑ Other_____

Has your child ever had a serious or difficult problem associated with dental work or a dental visit? ❑ Yes ❑ No
If Yes, please explain _____

Does your child brush his/her teeth daily? ❑ Yes ❑ No Does your child floss his/her teeth daily? ❑ Yes ❑ No

Patient Name _____

Health History

- ❑ Abnormal Bleeding
- ❑ ADD/ADHD
- ❑ AIDS/HIV+
- ❑ Allergies
- ❑ Anemia
- ❑ Asthma
- ❑ Autism
- ❑ Blood Disorders
- ❑ Blood Pressure, High/Low
- ❑ Bone/Muscular Disorders
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Cleft Palate/ Lip
- ❑ Congenital Birth Defects
- ❑ Convulsion/Epilepsy
- ❑ Depression/Anxiety
- ❑ Diabetes
- ❑ Disability/Special Needs
- ❑ Eating Disorder
- ❑ Epilepsy/Seizures
- ❑ Handicaps/Disabilities
- ❑ Cerebral Palsy
- ❑ Hearing Impairment
- ❑ Heart Disease/Murmur
- ❑ Hemophilia Type ___
- ❑ Hepatitis Type ___
- ❑ Hives
- ❑ Hospital Stays/Surgery
- ❑ Immune Disorders
- ❑ Kidney/Liver Condition
- ❑ Liver Problems
- ❑ Rheumatic/Scarlet Fever
- ❑ Tuberculosis
- ❑ Other_____
- ❑ None of the above

Please provide us with details regarding any medical conditions your child may have

_____

Primary Care Physician:_____ Phone#_____

List all medications your child is taking ❑ None

_____

_____

List any allergies (drugs, latex, etc.) ❑ None _____

_____

Dental Information Release Form

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information.

Please provide us with the name(s) and phone number of family and or any other affiliate of yours that you authorize us to discuss and or release patient information to.

_____

_____

_____

❑ Please do not release my information to anyone

HIPAA Acknowledgement

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides patients with important privacy rights and protections with respect to their health information, including important controls over how their health information is used and disclosed by health plans and health care providers. Please see the HIPAA Notice of Privacy Practices information that is found in the Patient Center located on the bottom of our web site prior signing/submitting your new patient information. You may print the information or receive a copy from our office.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand the above information and agree to its contents.

Signature: _____

Patient Name _____

Broken Appointment Policy

Realizing that we all have busy schedules and that unforeseen situations may occur, we wish to make you aware of the scheduling guidelines for our dental practice. If you find that you are unable to keep your scheduled appointment, we require **2 full business days** notice in order to prevent a failed appointment fee of **$50.00.** Please understand this is not something we desire to do.
I understand the above information and agree to its contents.

Initial _____ Patient Name **_____**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf.

I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant Dental Partners of Vero Beach permission to securely upload my patient information to the web site.

Signature: _____ Date: _____

Patient Name _____

Photograph, Electronic Images and Video Release

Re: Patient_____ DOB: _____

I _____grant permission to Dental Partners of Vero Beach its associates and affiliates, to take photographs, X-Rays, Electronic Images and Videos of my child.

Please Note: Photographs, images, X-rays and videos taken during treatment may be used by our laboratories for cosmetic purposes for the fabrication of crowns, bridges or dentures and are a part of your child's permanent dental records. In addition to being part of your permanent dental chart photos are extremely important when educating patients and potential patients. We appreciate being able to use photos/images taken for educational purposes. At Dental Partners of Vero Beach we perform unique and specialty services that are best conveyed and shared through photographs/images.

❑ I hereby grant Dental Partners of Vero Beach its associates, affiliates, publicity representatives, and representatives of the practice, permission to reproduce, publish, print, use, and distribute copies of such images to be included in my dental/medical chart. Images are used to diagnose and treat dental/medical conditions and may be shared with professional colleagues and educators for the purpose of treatment success. In addition, I grant them permission for my images to be used in medical publications, in the form of prints, slides or film for the use in connection with articles, lectures, and promotional pieces dealing with the head, neck, jaw, dental disorders or cosmetic renovations. I specifically waive any claim for invasion of my personal privacy, which might accrue to me on account of the use of such images without my express consent in each instance. Initial _____

❑ I agree to allow Dental Partners of Vero beach to use my photos anonymously as long as no full faces are shown for the purposes of education, social media or marketing. I waive any right to royalties or other compensation arising from or related to the use of photographs or video. No full face or identifying photo will be taken without your written consent for each photo, unless authorized by this agreement. Each case will be discussed prior to any photo release. Initial _____

❑ I agree to allow Dental Partners of Vero Beach to use my child's photos, images and videos, full face view, for the purpose of social media and or other marketing materials, and I waive any right to royalties or other compensation arising from or related to the use of the photographs and or video. Initial _____

❑ I hereby waive any right to inspect or approve the photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown. I waive any right to royalties or other compensation arising from or related to the use of the photographs, images and or video. Initial _____

❑ I DO NOT AGREE to allow Dental Partners of Vero Beach to use my child's photos for social media and or other marketing materials. I understand and agree to allow images of my child's photos and x-rays to only be used for the purpose of my child's dental treatment and records ONLY. Initial _____

I have read this release before signing below, and I fully understand the contents, meaning and impact of this release.

_____	_____	_____
Print Name (Parent or Guardian)	Signature	Date