

**Your Child's Information**

Name: (First) \_\_\_\_\_ (Last) \_\_\_\_\_ (MI) \_\_\_\_\_ (Preferred) \_\_\_\_\_ Date: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender:  Male  Female

Parent or Guardian's E-mail Address: \_\_\_\_\_

Child's Home Address: (Street) \_\_\_\_\_ (Number) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_

Home Phone: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Immediate family members seen in our office: \_\_\_\_\_

**MEDICAL HISTORY**

- AIDS/ HIV
- Acid Reflux/GI/Stomach
- Allergies (seasonal)
- Anemia/ Blood Disease
- Arthritis
- Artificial Joints
- Asthma
- Cancer
- Diabetes
- Dizziness/ Fainting
- Epilepsy
- Excessive Bleeding
- Eye Disorder
- Growths/ Tumors
- Head Injuries
- Heart Disease
- Heart Disorder/ Problem
- Heart Murmur/ MVP

- Hepatitis/ Jaundice
- Immune Disorders
- Jaw Pain/TMD/TMJ
- Kidney Disease
- Liver Disease
- Mental Disorder
- Nervous Disorder
- Pacemaker
- Radiation / Chemotherapy
- Respiratory Problems
- Sinus Problems
- Thyroid Disorder

**DRUG ALLERGIES**

- Codiene Allergy
- Latex Allergy
- Penicillin Allergy
- Other \_\_\_\_\_

**DENTAL HISTORY**

- Bad Breath
- Bite/ Chew Nails
- Biteguard Therapy
- Bleaching Treatment
- Bleeding Gums
- Blisters/ Sores on Lips
- Broken Fillings/ Teeth
- Cheek/ Lip Biting
- Smoking/ Tobacco
- Clench/ Grinding Teeth
- Gums Swollen or Tender
- Jaw Pain or Tiredness
- Mouth Breathing
- Orthodontic Treatment
- Thumb/ Finger Sucking
- Wisdom Teeth Removed

Any Dental Injuries? \_\_\_\_\_

If so, please describe and provide date(s):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does your child take antibiotics (premed) for dental appts? \_\_\_\_\_ If so, what antibiotic? \_\_\_\_\_

Does your child take Coumadin, Plavix or other blood thinners? \_\_\_\_\_ If so, what? \_\_\_\_\_

Please list Any Medications that your child is now taking (continue on back or attach list if needed);

Name and phone number of your child's pediatrician/ medical doctor: \_\_\_\_\_

Any Health Problems Not Already Listed (Please Explain): \_\_\_\_\_

**Referral Information**

Who may we thank for referring you to our office?  Another patient \_\_\_\_\_

Dental Office \_\_\_\_\_  Insurance \_\_\_\_\_  Internet  Phone Book  Other \_\_\_\_\_

### Dental Insurance Information

**Primary Insurance:**

Insurance Plan Name: \_\_\_\_\_ Ins. Co. Phone #: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Policy Holder's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Employer Name: \_\_\_\_\_

Patient's relationship to policy holder:     Self     Spouse     Father     Mother     Guardian**Secondary Insurance:**Insurance Plan Name and Address: \_\_\_\_\_  
\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_

Holder's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

### Consent For Services

I have read and understand the above information. To the best of my knowledge, I have accurately answered the above questions. I understand that providing incorrect information can be dangerous to my health. If there is any change in my medical status, I will inform the dentist. I understand that this information will be used by my dentist to determine appropriate and healthful dental treatment. I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to me during the period of such care to third party payers and/ or other health practitioners.

*Signed:* \_\_\_\_\_ *Date:* \_\_\_\_\_ *Relationship to Patient:* \_\_\_\_\_

### EMERGENCY CONTACT:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Hammer and Van Zant Dental Cancellation Policy:**

If you need to cancel your appointment with us, we require at least 24 hours notice. This gives us the opportunity to provide care to another patient who can use the appointment time. If 24 hours notice is not given for two appointments, we reserve the right to not schedule you for any more appointments, and to discharge you as a patient.

I have read and understand the cancellation policy.

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**Hammer and Van Zant Dental**  
**Brian C Hammer, DMD and Assoc, PSC**

**PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPPA)**

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability And Accountability Act of 1996. I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment); Obtaining payment from third party payers (e.g. my insurance company); The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

**HAMMER AND VAN ZANT DENTAL**  
**Financial Policy**

Payment is expected at the time service is rendered.

Methods of payment include:

- Cash/ check, Visa, Master Card, Discover, Care Credit

If you have dental insurance, we will be happy to file your claims with your primary carrier. You will be expected to pay your deductible and percentage the day treatment is provided. We will file and allow up to 60 days for an insurance response before contacting you. If your claim is denied and/or payment is delayed, *you will be expected to pay the claim amount.*

**IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS OF YOUR POLICY, INCLUDING ITS LIMITATIONS AT THE TIME OF TREATMENT.**

We will help you as much as we are able; however, it is impossible for us to know all of the details and limitations of every insurance policy. IF an insurance company denies payment, the unpaid portion becomes the patient's responsibility. We are not responsible for anything an insurance company denies payment for.

**If your account is unpaid and goes to a collection agency, we will no longer be able to see your family due to the deteriorating patient/ doctor rapport.**

Parents, guardians, and/or personal representatives are responsible for all fees and services rendered for treatment of a minor/child on the day of service.

I have read and understand and acknowledge my HIPAA rights. (The section at the top of this page).

I have read and understand the financial policy. (The section just above this section on this page).

Print Name: \_\_\_\_\_ Sign: \_\_\_\_\_ Date: \_\_\_\_\_