Fishers Pediatric Dentistry

PATIENT INFORMATION & MEDICAL HISTORY UPDATE

All questions contained in this questionnaire are strictly confidential and will become part of the patient's record.
A Medical History Update must be provided at ***every*** dental visit.

INDICATE CHANGES TO THE FOLLOWING (check all that apply):

☐ MARITAL STATUS ☐ INSURANCE ☐ ADDRESS/PHONE/EMAIL ☐ GUARDIANSHIP ☐ MEDICATION/ALLERGIES

PATIENT INFORMATION

Patient's First & Last Name: _____ Date of Birth: _____

Patient's Primary Address: _____
City State Zip Code

Who does the patient live with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Parent's/Guardian's First & Last Name:_____ E-mail Address: _____

Primary Cell # for Appointment Confirmations & Communications: _____ Secondary # _____

You will receive text message communications to the cell number provided related to appointment reminders, healthcare information and billing matters. Please note you may be charged message and data rates by my wireless carrier. Such messages may be generated by an automated messaging system, and you may opt-out of this service by replying ***STOP*** *to any message.*

Who is accompanying the child on the date of their appointment? _____
(First & Last Name)

Relation to patient: ☐ Biological ☐ Adopted ☐ Foster ☐ Nanny ☐ Other: _____

Is the child a ward of the state? ☐ Yes ☐ NO If yes, case worker's contact number: _____

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

Below is a list of ways that our office may contact you. Please check all that apply. Checking a box will give permission to leave as thorough of a message as needed.

☐ PHONE NUMBER: _____ ☐ EMAIL:_____

Patient Authorization for Use and Disclosure of Protected Health Information:
I authorize Fishers Pediatric Dentistry to release any information including diagnosis and the records regarding any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners. ***In the event of my absence, the following individual(s) may bring my child/children to and from their appointments along with have access to medical and financial information.***

FIRST NAME: LAST NAME: RELATIONSHIP: CONTACT #:

FIRST NAME: LAST NAME: RELATIONSHIP: CONTACT #:

I have been offered a copy of this office's Notice of Privacy Practices: **(initial)** ☐

OFFICE POLICIES / FINANCIAL AGREEMENT

I certify that the information I have given is correct to the best of my knowledge. It will be held in confidence, and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly Fishers Pediatric Dentistry all insurance payments otherwise payable to me. **I understand that I am responsible for the full balance of the account regardless of my dental benefits.** I acknowledge that the office operates on a **15-day billing cycle** and account balances are due and payable when the statement is issued and is past due if not paid by the date printed on the statement. Past due accounts will incur late charges between **$10 and $25** and can be sent to a collection agency if unpaid. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist or any member of the staff responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. **I affirm that my signature represents my agreement to all the above mentioned terms.**

Print First & Last Name:_____ Signature:_____ Date: _____

GENERAL HEALTH SCREENING / MEDICAL HISTORY UPDATE

Has the patient had any of the following within the past 14 days: (please check all that apply or 'none')

☐ Fever (temp above 100.4) ☐ Dry Cough ☐ Sore throat ☐ Loss of taste or smell ☐ Flu-like symptoms ☐ None

Consent is given for Fishers Pediatric Dentistry to provide treatment to the patient listed above. I understand that there may be risks being in the proximity of dentists, patients and staff, and will hold harmless against any claims & actions in the event I &/or the above-mentioned patient become infected with COVID-19 or any other infectious disease while being treated. I understand that due to the unknowns, the number of patients that have been in the practice and nature of the procedures performed here, I &/or my child have an increased risk of contracting the virus by being in the practice facility and/or by receiving treatment. **(initial)** ☐

CONDITIONS	**Does the patient have any MEDICAL CONDITIONS?** ☐ Yes ☐ No (For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal Allergies, etc)
	If YES, what conditions?
	Does the patient have any HEART conditions? ☐ Yes ☐ No (For example: Heart Murmur, Congenital Heart Defect, etc)
	If YES, what conditions?
	Does the patient require an ANTIBIOTIC before being seen? ☐ Yes ☐ No If YES, did the patient take the antibiotic? ☐ Yes ☐ No
	Is the patient followed by a specialist ☐ Yes ☐ No If YES, provide name and contact number:
ALLERGIES	**Does the patient have an ALLERGY to LATEX?** ☐ Yes ☐ No **Does the patient have an ALLERGY to TREENUTS?** ☐ Yes ☐ No
	Does the patient have any OTHER ALLERGIES? ☐ Yes ☐ No (For example: Animals, Foods, Medications, Nickel, etc)
	If YES, what allergies?
MEDICATIONS	**Is the patient currently taking ANY medications/vitamins?** ☐ Yes ☐ No
	If YES, what medications/vitamins? Why is the patient taking this medication (i.e., what condition is it for)?
DENTAL CONCERNS	**Do you (or the patient) have any DENTAL CONCERNS?** ☐ Yes ☐ No
	If YES, what concerns do you have?
CONSENT FOR TODAY	**X-Rays (if needed):** ***Essential for diagnosing tooth decay and other abnormalities*** ☐ Yes ☐ No **Fluoride Application:** ***To help fight tooth decay and strengthen developing teeth*** ☐ Yes ☐ No

Print Name: _____Signature: _____Date:_____