BRICE DENTAL
Making Friends Smile
GENERAL & IMPLANT DENTISTRY

CHILD HEALTH RECORD

Today's Date:_______________

Full Name_______________ Age_______ Date of Birth_______________

Home Adress_______________ City_______________ State_______ Zip_______

Names of Both Parents_______________ Hm. Phone_______________

Father's Employer_______________ Soc. Sec._______________ Work Phone_______________ Cell Phone_______________

Mother's Employer_______________ Soc. Sec._______________ Work Phone_______________ Cell Phone_______________

Dental Insurance Co._______________ Group No._______________

Whom may we thank for referring you?_______________

Other family members seen by us_______________

Reason for this visit_______________

Name and address of a relative not living with you. _______________

DENTAL HISTORY

Question		
How long since your child's last dental visit?		
Is he/she having problems now? If yes, explain.	YES	NO
Has your child had any unhappy dental experiences?	YES	NO
Has your child had any injuries to his/her mouth, teeth or head? If yes, explain.	YES	NO
Has your child had nitrous oxide before (laughing gas)?	YES	NO
Would you like them to have laughing gas for dental treatment?	YES	NO
Does your child have any mouth habits? Thumb sucking, nail biting, mouth-breathing, nursing bottle habits, etc.?	YES	NO
Does your child have any unusual speech habits?	YES	NO
Has orthodontic treatment been recommended?	YES	NO
Does your child brush their teeth daily?	YES	NO
Do you assist your child with brushing their teeth?	YES	NO
Is dental floss used?	YES	NO

MEDICAL HISTORY

Has your child ever had any of the following?

Condition		
Heart problems	YES	NO
Diabetes	YES	NO
Fainting spells, seizures, or epilepsy	YES	NO
Ulcers or stomach problems	YES	NO
Nervous problems	YES	NO
Asthma or any respiratory problems	YES	NO
Hepatitis, or any liver damage	YES	NO
Abnormal Bleeding	YES	NO
Surgery or Radiation for any growths, cancer or tumors	YES	NO
Is he/she taking ANY MEDICATIONS now Name them:	YES	NO
Is he/she ALLERGIC TO PENICILLIN	YES	NO
ANY OTHER DRUG ALLERGIES If so, to what	YES	NO
Is your child under a PHYSICIAN'S CARE right now If so, explain		
FAMILY PHYSICIAN:_______________ PHONE#:_______________		
Is there any other MEDICAL OR DENTAL information that you feel I should know about?		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Insurance Agreement: I certify that I and/or my dependents have insurance coverage with _______________
Name of Insurance Company
and assign directly to Dr. Brice all insurance benefits. If any otherwise payable to me for services rendered I understand that I am financially responsible for all charges whether or not paid by insurance. Any benefit coverage quoted is an estimate based on the most current information available to us. Billing and/or interest charges are applied to balances over 30 days (rate of 1.56% or min. $1.00 authorize the use of my signatures on all insurance submissions.
Dr. Brice may use health care information and may disclose such information to the above-named Insurance Companies and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related services.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Brice's Notice of Privacy Practices.

X:_______________ Date:_______________

Signature of Patient, Parent or Guardian

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ____________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITYS IN THE FUTURE.

______________________________ ______________________________
Please ***print*** your name Please ***sign*** your name

______________________________ ______________________________
Legal Representative Description of Authority

Your comments regarding Acknowledgements or Consents: ______________________________

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HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:
☐ First Name Only ☐ Proper Sur Name ☐ Other ____________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):
Name: ______________________________Relationship: ____________________

Name: ______________________________Relationship: ____________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:
It was emergency treatment
I could not communicate with the patient
The patient refused to sign
The patient was unable to sign because
Other (please describe) __

Signature of Privacy Officer ______________________________