PEDIATRIC DENTISTRY OF LOVELAND

Katherine S. Galm, D.D.S.

Please fill out this form and bring it with you on your first office visit.

About Your Child

Child's Name _____
First Middle Last

Preferred Name: _____

Age _____ ☐ Male ☐ Female

Date of Birth _____ Weight _____

Reason for Visit _____

_____

How did you hear about our office? _____

School Name _____ Grade _____

Preventative Dental History

How often does your child brush? _____

Is tooth brushing supervised? ☐ Yes ☐ No

If yes, by whom? _____

Is dental floss used? ☐ Yes ☐ No

Does your child receive:

☐ Regular toothpaste ☐ City tap water
☐ Non-fluoride toothpaste ☐ Bottled water
☐ Infant/training toothpaste ☐ Well water
☐ Fluoride rinse

What does your child drink most often?

_____

Dental History

Is this your child's first dental visit? ☐ Yes ☐ No

Previous Dentist _____

City, State _____

Date of Last visit _____

Date of Last X-Rays _____

Any Injuries to your child's teeth? ☐ Yes ☐ No

If yes, when? _____

History of:	*When?*
☐ Breast feeding	_____
☐ Bottle/sippy cups habits Does your child take a bottle or cup to bed ☐ Yes ☐ No	_____
☐ Thumb/finger sucking	_____
☐ Pacifier	_____
☐ Dental grinding or clenching	_____

Has your child had any unfavorable past dental experiences? ☐ Yes ☐ No

If yes, explain _____

_____

Has your child had recent dental pain? ☐ Yes ☐ No

If yes, explain _____

_____

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Medical History

_____
Name of Child's Physician

_____ _____
Address *Phone Number*

_____
Date of Last Physical Exam

- Is your child presently under the care of a specialist for any medical reason? ☐Yes ☐No

  If yes, for what? _____

  _____ _____
  Specialist's Name *Phone Number*
- Does your child have a history of health problems? If yes, explain: ☐Yes ☐No _____

  _____
- Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt, organ transplant or other medical reason? ☐Yes ☐No
- Is your child presently taking any medications? If yes, what? ☐Yes ☐No _____

  _____
- Has your child ever been hospitalized or had surgery? For what? ☐Yes ☐No _____
- Does your child have any allergies? If yes, what? ☐Yes ☐No _____
- Has any member of the family, including your child, had a problem with a general anesthetic? ☐Yes ☐No

Medical Conditions

Has your child ever been diagnosed as having any of the following conditions? Check all that apply.

☐ Acid Reflux
☐ AIDS-HIV
☐ Anemia
☐ Arthritis
☐ Asthma, if ☑ what triggers it? _____
☐ Autism
☐ Bladder Conditions
☐ Blood Disease
☐ Birth Defects
☐ Bone or Joint Problems
☐ Brain Injury
☐ Bruising Easily
☐ Cancer or Malignancies
☐ Cerebral Palsy
☐ Chemotherapy/Radiation
☐ Child Abuse
☐ Chronic Adenoid/Tonsil Infections
☐ Chronic Ear Infections
☐ Cleft Lip/Palate
☐ Congenital Heart Lesion
☐ Convulsions/Seizures
☐ Developmentally Disabled
☐ Diabetes
☐ Drug Addiction
☐ Ear stuffiness, Itching, or Noises
☐ Emotional Disturbance
☐ Epilepsy
☐ Eye Problems
☐ Excessive Bleeding Problem
☐ Excessive Gagging
☐ Fainting or Dizziness
☐ Fever Blisters (Cold Sores)
☐ Growth/Developmental Problems
☐ Headaches
☐ Hearing/Speech Impairments
☐ Heart Defect
☐ Heart Murmur
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis or Liver Disease
☐ High Blood Pressure
☐ Hyperactivity/ADD or ADHD
☐ Kidney Disease
☐ Leukemia
☐ Mental Disability
☐ Mouth/Canker Sores
☐ Nutritional Deficiency
☐ Orthopedic Problems
☐ Pain in Jaw Joints
☐ Premature Birth
☐ Psychiatric Care
☐ Rheumatic Fever
☐ Scoliosis
☐ Sickle Cell Anemia
☐ Syndrome _____
☐ Tuberculosis

☐ Other _____

Primary Dental Insurance

Insurance Co. _____
Policy Holder Name _____
Employer _____
Policy Holder SSN# _____
Group # _____
Member ID _____
Claim Address _____
Claim City _____ State _____ Zip _____
Insurance Co. Phone No. _____

Secondary Dental Insurance

Insurance Co. _____
Policy Holder Name _____
Employer _____
Policy Holder SSN# _____
Group # _____
Member ID _____
Claim Address _____
Claim City _____ State _____ Zip _____
Insurance Co. Phone No. _____

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Responsible Party - Mother

☐ Mother
☐ Other _____

Name _____ Birthdate _____

Address _____

City _____ State _____ Zip _____

Does child live at this address? ☐ Yes ☐ No

Phone _____

Email _____

Note: Phone and email required to send appt. notification

Were you or your spouse a patient? ☐ Yes ☐ No

Responsible Party - Father

☐ Father
☐ Other _____

Name _____ Birthdate _____

☐ Same as Mother

Address _____

City _____ State _____ Zip _____

Does child live at this address? ☐ Yes ☐ No

Phone _____

Email _____

Emergency Contact

(other than responsible party)

Name _____

Phone _____

Authorization

*I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that **payment is due at the time services are rendered**. I also request that payment under my dental insurance program be made directly to Pediatric Dentistry of Loveland on any unpaid bills for services furnished to me or my family. I authorize the release of any dental information necessary to process this claim and all future claims. If my bill is not paid, I am liable for collection fees.*

By providing us with your phone numbers, you give us express authorization to contact you at those numbers. This express authorization also applies to any landline/cell phone numbers you acquire in the future. Phone calls to you may be made utilizing automated dialer technology. Providing your phone number is not a condition of receiving services.

***No-show Policy:** You also agree to give timely notice if you are unable to make an appointment. When we schedule an appointment for your child we are holding that time for you. Our dentists and assistants have very full schedules. If you need to cancel, please let us know as early as possible so that others can be served.*

The permission of a parent or guardian is necessary for dental treatment of a minor.

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (X-rays), and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, anesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions that my child's medical doctor has advised me should be reported to a dentist.

_____ _____ _____

Signature ***Relationship to Child*** *Date*

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Notice of Privacy Practices

This notice describes how your health information may be used and disclosed, and how you can access this information. Please review it carefully.

At Pediatric Dentistry of Loveland, we are required to keep your health information secure and confidential, by law. Also by law, we need to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your treatment or progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your treatment information into our computer system.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information to you. We may also call and remind you about your appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We will need to release some or all of your health information, when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose some or all of your health information as described above. We will let you know if we can fulfill your request.

You have the right:

- *to know of any uses or disclosures we make with your health information beyond the above normal uses.*
- *to receive communication about your health information in the manner you prefer. We will also use whatever communication method, number or system you prefer to contact you.*
- *to transfer a copy of your health information to another practice. Notify us in writing of where you would like us to send a copy of your health information for you.*
- *to see and receive a copy of your health information, with a few exceptions. Give us a written request regarding the information you want to see. If you want a copy of your records, we may charge you a reasonable fee for the copies. If you would like a digital copy of your records, let us know which type of file you would like and we will try to meet your needs.*
- *to request an amendment or change to your health information, in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but will add new information.*
- *to receive a report of whom we disclose your information to.*

If our privacy and security measures or systems are breached in any way, we will notify you.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services in writing (200 Independence Avenue, S.W., Room 509F, Washington, DC 20201), online (http://www.hhs.gov) or by email (OCRComplaint@hhs.gov). You will not be retaliated against for filing a complaint.

Please contact our Privacy Officer, at 970-669-7711 for more information, to make a request, to file a complaint with us or for assistance regarding your health information privacy.

Acknowledgment

Date

Parent Signature

Print Parent Name

Patient Name 1

Patient Name 2

Patient Name 3

Patient Name 4