New Patient Questionnaire

Reset

Patient's Information

Last Name:	Middle:	First Name:
Name Preferred:	D.O.B:	Social Security #:
Sex: Female	Age:	Home #:
Address:	Apt. #	City:
State:	Zip:	

GUARDIAN INFORMATION

Last Name:	Middle:	First Name:
Marital Status: Single	D.O.B:	Social Security #:
Email:	Sex: Female	Does Child live with you?

Whom may we Thank for Referring you to us: Drive by

Please give insurance card to Receptionist	
Subscriber's Name	
Subscriber's D.O.B.:	Social or ID #:
Subscriber's Employer:	
Subscriber's Employer Address:	
Address Continued:	

IN CASE OF EMERGENCY

Name of local Friend or Relative (not living at the same address) : _____

Relationship to patient:_____ Phone #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the Physician. I understand that I am financial responsible for any balance. I also authorize Under The Sea Children's Dentistry or insurance company to release any information required to process my claims.

Guardian Signature: _____ Date: _____

OFFICE POLICY ON MISSED APPOINTMENTS

In order to keep our dental fees as low as possible, we ask that you give us 24 hours' notice if you cannot keep an appointment. Repeated broken or missed appointments may result in our being unable to give your child further appointment's. **We must be able to contact you to confirm appointment by 12:00 noon the day before the appointment or your appointment may be cancelled at our discretion.**

Guardian's Signature:_____ Date: _____

Under the Sea
CHILDREN'S DENTISTRY

New Patient Questionnaire

FINANCIAL STATEMENT

Normally payment for dental treatment is expected when services are performed. We accept checks, cash, Visa, or Mastercard. If you have dental insurance, we will be happy to file any claims, however you are responsible for your account. We try to give you as close an estimate of the portion of the fee that is covered by your insurance as we can. **Please understand that this is only an estimate based on information your insurance company provides to us.** Dental coverage on your child rarely cover all expenses. Obligation form payment still belongs to you. You will receive a statement each month. Any overpayments will be refunded after all insurance payments have been received by our office and all checks have cleared the bank. Any accounts delinquent over 90 days will be turned over to a collection agency. There is a $30.00 charge for returned checks and any returned check not paid in cash on demand will be turned over to the district attorney for prosecution.

Guardian's Signature: _____ Date: _____

HEALTH HISTORY

DENTAL		MEDICAL	
What is the main reason of your child's visit today?		Is your child in good health?	
Date of last dental visit?		Comments:	
Has child complaint of dental pain?		Are immunization's current?	
Does child suck thumb or finger or uses a pacifier?		Is child taking any medications?	
Does your child take fluoride vitamins?		If so, what and why?	
Has your child had an unhappy dental experience?		Has your child ever had an unfavorable drug reaction?	
Do you desire complete dental treatment?		Indicate any allergies your child may have:	
Are you interested in braces?			

PLEASE CHECK ALL CONDITIONS YOUR CHILD MAY HAVE:

☐EPILEPSY
☐CANCER
☐HEPATITIS
☐HEMOPHILIA
☐TUBERCULOSIS
☐ANEMIA
☐SINUSITIS
☐HEART MURMUR
☐RHEUMATIC FEVER
☐ASTHMA
☐SEIZURES
☐KIDNEY PROBLEMS
☐THYROID PROBLEMS
☐HEART PROBLEMS
☐DIABETES
☐LIVER PROBLEMS
☐CEREBRAL PALSY
☐GLAUCOMA
☐DEVELOPMENTAL PROBLEMS
☐SPECIAL NEEDS
☐AIDS-HIV
☐PREGNANCY
☐GENETIC DISORDER
☐LATEX ALLERGY
☐PERSISTANT COUGH
☐OTHER:_____

Guardian's Signature:_____ Date:_____

HIPPA VERIFICATION

Please sign below if you have read and understood the information for your knowledge of the HIPPA (Privacy Practices). Any question feel free to ask the front Desk.

Guardian's Signature: _____ Date: _____

Under the Sea
CHILDREN'S DENTISTRY

New Patient Questionnaire

AUTHORIZATION FOR ELECTRONIC CHART IDENTIFICATION PHOTOGRAPH

Patient Name: _____ Date of Birth:_____

Under The Sea Children's Dentistry will be using electronic medical records to maintain your Child's health care information. The use of electronic medical records allows Under the Sea to store a digital photograph of a patient in their electronic chart so that Under the Sea Children's Dentistry Doctor and staff may visually identify such patient while reviewing his or her chart.

Under the Sea Children's Dentistry will only use this patient's photograph for identification purposes. This photograph will not be release and will not be shown to anyone other than Under the Sea Doctor and staff. Under the Sea is committed to maintaining the privacy and confidentiality of all patient's health information in compliance with HIPAA.

The above-named patient's Guardian may, at any time, withdraw this consent with written notice to Under the Sea Children's Dentistry.

PLEASE CHECK ONE:

☐ **YES**. I allow Under the Sea Children's Dentistry to take a digital photograph of my son/daughter to be stored in the electronic medical records system. I understand that by checking "YES" and signing this form, I am giving Under the Sea permission to take a digital photograph for our electronic medical records system.

☐ **NO**. I do not wish for Under the Sea Children's Dentistry to take my son/daughters photograph for the purpose of electronic medical records system.

By signing this consent the guardian acknowledges that he/she has read the above information and fully understands it, and agrees to be bound by it.

Childs Name:_____

Guardian Signature: _____

Date: _____

Relationship to Patient: _____