Children's Dental Health
— ORTHODONTICS —

To help us better serve you, please complete the following forms to the best of your ability.
If you have questions, do not hesitate to let us know. Thank you for choosing our office!

Child's Name: _____ **DOB (MM/DD/YY):** _____

Nickname: _____ **Age:** _____ **Social Security #:** _____

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Declined **Gender:** ☐ Male ☐ Female ☐ Other ☐ Undecided

Race: ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander
☐ Other ☐ Declined

Home Address: _____

City, State, Zip: _____ **Phone Number:** _____

Who can we thank for referring you to us? (Please check all that apply.)

☐ Primary Care Doctor _____
☐ General Dentist _____
☐ Friend/Family _____
☐ School/Daycare _____

How have you heard about us? (Please check all that apply.)

☐ Social Media
☐ Google/Website
☐ Insurance Directory
☐ Drive-by/Signage
☐ Billboard
☐ Newspaper or magazine feature/ad
☐ School/Daycare
☐ Community Event/Festival
☐ Commercial or video
☐ Other _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Mother/Guardian)

Name: _____ **Relationship:** _____

DOB: _____ **Social Security #:** _____ **Email Address:** _____

Home Address (if different than child): _____

City, State, Zip: _____ **Phone Number:** _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Father/Guardian)

Name: _____ **Relationship:** _____

DOB: _____ **Social Security #:** _____ **Email Address:** _____

Home Address (if different than child): _____

City, State, Zip: _____ **Phone Number:** _____

PRIMARY DENTAL INSURANCE:

Insurance Company: _____ **Insured's Name:** _____

Relationship to Patient: _____ **DOB:** _____ **Social Security #:** _____

Employer: _____ **Subscriber's ID:** _____ **Group #:** _____

SECONDARY DENTAL INSURANCE:

Insurance Company: _____ **Insured's Name:** _____

Relationship to Patient: _____ **DOB:** _____ **Social Security #:** _____

Employer: _____ **Subscriber's ID:** _____ **Group #:** _____

FINANCIAL ARRANGEMENTS/INSURANCE AGREEMENT

I authorize the treating provider to release any information, including the diagnosis and the records of treatment or examination rendered to my child during the period of such care, to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

Any unpaid balance due (as listed on a billing statement), not paid within 28 days of the monthly billing date, will be assessed a late charge of 1.5% each month. I realize that failure to keep this account current may result in my children being unable to receive additional dental services except for dental emergencies or when there is pre-payment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection cost (33% of the unpaid balance), postage, attorney, and court fees incurred in attempting to collect on this amount or any future outstanding balances.

I hereby authorize the office to contact the designated phone numbers and/or email address listed in the patient's account. With this authorization, a message/communication may be left indicating appointment time and dates, reminders, balances due, and/or estimated co-pays for future visits.

Financially responsible person for account ☐ Self ☐ Other _____

_____

Signature of Parent or Legal Guardian **Date**

☐ Child in foster care - Children & Youth and Foster Parents will not sign **Staff Initials** _____

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protection health information to carry out treatment, payment activities, and healthcare operations. You also consent to having been provided with access to a copy of the company's Notice of Privacy Practices.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters regarding your protected health information and your patient rights under HIPAA. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time from the dental office, our website, or by contacting our Privacy Officer:

Contact: Jim DeFruscio

Telephone: 484-787-2943

Email: privacy@ChildrensDentalHealth.com

Address: 200 Willowbrook Lane, Suite 220, West Chester, PA 19382

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat your child if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

If this consent is signed by a personal representative, on behalf of the patient, complete the following:

Patient's Name: _____

Relationship to Patient: _____

Personal Representative's Name: _____

_____

Signature **Date**

YOU ARE ENTITLED TO A COPY OF YOUR PAPERWORK AFTER SIGNED.

MEDICAL HISTORY

Child's Physician: _____ **City:** _____ **Phone:** _____ **Date Last Seen:** _____

Is your child presently under the care of a physician for any medical issue? ☐ Yes ☐ No

If yes, please describe: _____

Is your child currently taking medication? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever been hospitalized for surgery? ☐ Yes ☐ No

If yes, please describe: _____

Does your child have allergies to any food or medication? ☐ Yes ☐ No

If yes, please describe: _____

Is your child pregnant? ☐ Yes ☐ No

Does your child have a history of:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Murmurs	☐	☐	Diabetes	☐	☐	Hearing Impairment	☐	☐	Cancer/Tumors
☐	☐	Heart Trouble	☐	☐	Asthma	☐	☐	Speech Problem	☐	☐	Chemo/Radiation Therapy
☐	☐	Allergies	☐	☐	Epilepsy	☐	☐	Anemia	☐	☐	Leukemia
☐	☐	Allergy or Sensitivity to Anesthesia	☐	☐	Seizures/Convulsions	☐	☐	ADD/ADHD	☐	☐	Hepatitis
☐	☐	Drug Sensitivities	☐	☐	Recurrent Headaches	☐	☐	Autism/Asperger's	☐	☐	Bleeding Problems
☐	☐	High Temperature	☐	☐	Fractured Jaw	☐	☐	AIDS/ARC/HIV	☐	☐	Blood Disorders
☐	☐	Brain Injury/Concussion	☐	☐	Lung Problems	☐	☐	Kidney/Liver Involvement	☐	☐	High Blood Pressure
☐	☐	Vision Problems	☐	☐	Artificial Prosthesis	☐	☐	Nervous System Issues	☐	☐	History of Blood Transfusion
☐	☐	Premature Birth	☐	☐	Congenital Birth Defects				If yes, date of transfusion: _____		

Is there anything else regarding your child's physical, mental, or emotional health you feel we should know? ☐ Yes ☐ No

If yes, please describe: _____

DENTAL HISTORY

Dental Practice: _____ **Dentist Name:** _____

Date of Last Dental Appointment: _____ **What was performed:** ☐ Cleaning ☐ Other: _____

Have you recently been seen by an Orthodontist? ☐ Yes ☐ No

Have you ever had a Consultation with an Orthodontist? ☐ Yes ☐ No

Have you ever had braces? ☐ Yes ☐ No

Please describe the reason(s) for seeking orthodontic treatment?

_____

_____

Has your child experienced any unfavorable reaction from previous medical or dental care? ☐ Yes ☐ No

If yes, please describe: _____

PERMISSION FOR OTHERS TO ESCORT CHILD TO DENTAL APPOINTMENTS

We understand there may be times when you are unable to attend your child's dental appointment. To help make your visit as prompt and pleasant as possible, please provide the following information:

I, _____hereby give the following individual(s) my permission to bring my child/children to the practice and, in effect, have access to private information about their treatment. I recognize that during the course of the treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I hereby authorize the listed individual(s) to consent to the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well-being in the professional judgement of the treating provider. I authorize the company and its employees to discuss all dental and medical information with the following individual(s) listed below.

Name of Individual _____ **Relationship to patient** _____

Name of Individual _____ **Relationship to patient** _____

Name of Individual _____ **Relationship to patient** _____

_____

Signature **Printed Name** **Date**

CONSENT FOR ORTHODONTIC PRE-TREATMENT EXAMINATION AND DISCLOSURE OF POLICY REGARDING PREPARATION OF PRE-TREATMENT RECORDS

I have been informed that a pre-treatment examination and preparation of orthodontic records are necessary for an orthodontist to make specific recommendations for my care. Pre-treatment orthodontic records include a panoramic x-ray, cephalometric x-ray, facial and intraoral digital photographs, and alginate impressions or an intraoral scan for the creation of study models. I hereby consent to this complete orthodontic examination and to taking any necessary pre-treatment orthodontic records.

I understand that undergoing the pre-treatment examination and the making of pre-treatment orthodontic records does not create a contract or guarantee that CDH Orthodontics, their agents, and employees will provide me with orthodontic treatment. I have been informed that should I decide to go forward with orthodontic treatment, a separate contract will have to be signed.

By signing this document, for treatment planning purposes, I hereby authorize CDH Orthodontics and their agents to obtain and share healthcare information verbally, or through written materials, with other healthcare providers. This can include the patient's dentist, physician or other healthcare providers, and/or any insurance providers and can include any information related to the treatment and care of the patient during their orthodontic treatment.

I certify that I have read and understand the above information. In addition, I certify that, if I am signing on behalf of a minor, I am a parent or guardian of the patient with the legal right to consent for his/her dental care.

Patient's Name: _____

Relationship to Patient: _____

Parent or Legal Guardian Name: _____

_____ _____

Signature **Date**

Witness Name: _____

_____ _____

Signature of Witness **Date**