OAKVILLE DENTAL CARE

WELCOME

The benefits of a healthy, happy smile are immeasurable. Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely.

The better we communicate, the better care we can provide for you.

ABOUT YOUR CHILD

First:_____ Last:_____ M.I.____

Birthday:___/___/_____ Age:_____ SSN:_____-____-_____

Address:_____ Apt._____

City:_____State:_____ ZIP:_____

Email:_____

Mobile #:( )____-_____

Home #:( )_____-_____ Work #:( )_____-_____

Who may we thank for referring you? _____

Other family seen by us:_____

MEDICAL HISTORY

Is your child currently under a physician's care? ___YES ___NO

Physician's Name:_____

Phone:( )_____-_____ Last visit date: ___/___/_____

Please explain:_____

_____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name:_____ Relation:_____

Phone #:( )_____-_____Alternate #:( )_____-_____

Thank you for filling out this form completely. It will allow us to serve you more effectively. If you should have a question at any time, please ask us.

We are happy to help!

ACCOUNT INFO

PERSON RESPONSIBLE FOR ACCOUNT

Name:_____ Relation:_____

Birthday:___/___/_____ Age:_____ SSN:_____-____-_____

Email:_____Mobile #:( )_____-_____

Home #:( )_____-_____ Work #:( )_____-_____

Billing Address:_____

City:_____ State:_____ ZIP:_____

INSURANCE

Provider Name:_____

ProviderAddress:_____

City:_____ State:_____

ZIP:_____ Provider's Phone: ( )_____-_____

Group #:_____

Insured's ID#:_____

Insured's Name:_____ Relation:_____

Insured's Birthday:_____

Insured's SSN:_____

Insured's Employer:_____ Phone:( )_____-_____

SECONDARY INSURANCE

Provider Name:_____

ProviderAddress:_____

City:_____ State:_____

ZIP:_____ Provider's Phone: ( )_____-_____

Group #:_____

Insured's ID#:_____

Insured's Name:_____ Relation:_____

Insured's Birthday:_____

Insured's SSN:_____

Insured's Employer:_____ Phone:( )_____-_____

CHILD'S MEDICAL HISTORY

Current Physical Condition? ☐ Good ☐ Fair ☐ Poor

Use tobacco in any form? ☐ Yes ☐ No

Taking any over-the-counter, prescription, or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Has your child ever been hospitalized for any reason? ☐ Yes ☐ No

Is your child physically, emotionally or mentally impaired? ☐ Yes ☐ No

Please list any other medical condition(s) that your child has had.

_____

Has a doctor ever told you that your child requires antibiotics prior to dental treatment? ☐ Yes ☐ No

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?

YES NO | Aspirin	YES NO | Erythromycin	YES NO | Penicillin
YES NO | Codeine	YES NO | Jewelry/Metals	YES NO | Tetracycline
YES NO | Dental Anesthetics	YES NO | Latex	YES NO | Other

Please list any other drugs/materials that your child is allergic to:

_____

HAS YOUR CHILD EVER HAD ANY HISTORY OF, OR CONDITIONS RELATED TO, ANY OF THE FOLLOWING?

YES NO | Acid Reflux	YES NO | Heart Surgery
YES NO | AIDS/HIV	YES NO | Hepatitis A
YES NO | Anemia	YES NO | Hepatitis B or C
YES NO | Arthritis (Gout)	YES NO | Hypoglycemia
YES NO | Asthma	YES NO | Immunizations
YES NO | Bladder	YES NO | Kidney
YES NO | Bleeding Disorders	YES NO | Liver
YES NO | Bones/Joints	YES NO | Measles
YES NO | Cancer	YES NO | Mitral Valve Prolapse
YES NO | Cerebral Palsy	YES NO | Mononucleosis
YES NO | Chicken Pox	YES NO | Mumps
YES NO | Chronic Sinusitis	YES NO | Pregnancy (teens)
YES NO | Cold Sores/Fever Blisters	YES NO | Psychiatric Problems
YES NO | Congenital Heart Defect	YES NO | Rheumatic Fever
YES NO | COPD	YES NO | Seizures
YES NO | Diabetes	YES NO | Sickle Cell
YES NO | Ear Aches	YES NO | Sleep Apnea
YES NO | Epilepsy	YES NO | Thyroid
YES NO | Fainting	YES NO | Tobacco/Drug Use
YES NO | Growth Problems	YES NO | Tuberculosis
YES NO | Hearing	YES NO | Veneral Disease
YES NO | Heart Murmur	

Please list any other medical condition(s) that your child has had:

_____

_____

WE'RE GLAD YOU'RE HERE!

To better serve you, please take just a couple of minutes to answer the following questions.

A LITTLE MORE INFORMATION

Please check any of the following problems that apply to your child:

- ☐ Sensitivity (hot, cold or sweet)
- ☐ Ear aches or neck pain
- ☐ Teeth or fillings breaking
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath
- ☐ Jaw pain
- ☐ Food impaction
- ☐ Difficulty sleeping

Does your child have or have they ever had orthodontics (braces)? ☐ YES ☐ NO

How often does your child brush? _____

How often does your child floss? _____

Is this your child's first visit to a dentist? ☐ YES ☐ NO

If not, when was the last visit date?_____

Previous dentist name? _____

Has your child ever had dental radiographs (x-rays)? ☐ YES ☐ NO

Does your child have any fear or anxiety about going to the dentist? ☐ YES ☐ NO

Are you familiar with Nitrous Oxide Sedation? (laughing gas) ☐ YES ☐ NO

Please define your child's eating habits:

_____

_____

_____

Does your child have any oral habits such as thumbsucking, pacifier use, or nailbiting?

☐ YES ☐ NO

Has your child ever had any injuries to the mouth, head or teeth?

☐ YES ☐ NO

Has your child ever had any problems with the eruption or shedding of teeth?

☐ YES ☐ NO

Does your child participate in active recreational activites?

☐ YES ☐ NO

On a scale of 1 to 5, with 5 being the highest rating:
(please circle the number that best applies)

How important to you is your child's dental health?

1 2 3 4 5

How would you rate your child's current dental health?

1 2 3 4 5

Where would you like your child's dental health to rate?

1 2 3 4 5

What are the most important things to you about your child's smile and oral health?

What is the most important thing to you about your child's dental visit today?

DISCLAIMER

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect or incomplete information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status. The undersigned hereby authorizes the Doctor, in order to make a thorough diagnosis of the patient's dental needs, to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by the Doctor. I understand the Doctor will advise me of any and all forms of treatment, medication and therapy that may be indicated in connection with _____ (name of patient). I also understand that the Doctor may choose and employ such assistance as deemed fit. I further understand that the use of anesthetic agents embodies certain risk. I understand that payment for Dental Services provided in this office for myself or my dependents is my responsibility, due and payable at the time services are rendered. **A 1.5% monthly finance charge will be applied to all accounts over 90 days past due.** There will be a $35 service charge on all returned checks. **I understand that the Doctor's Office requires 24 hours notice for appointment cancellations, and that I will be charged $75 for each appointment canceled less than 24 hours in advance.** In the event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees, as may be required to effect collection of this note. Please sign your name here, verifying that all information provided is true and complete.

_____
Print Name

_____ _____
Sign Here Date

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT.

OFFICE USE ONLY

I verbally reviewed the medical/dental information with the patient names herein.

Initials: _____

Date: _____

Doctor's Comments: _____

_____

OAKVILLE DENTAL CARE

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES: By signing this form, I acknowledge that I have access to the Notice of Privacy Practices for Oakville Dental Care via the office or website at www.oakdc.com. By signing this form, I also consent to Oakville Dental Care's use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

RIGHT TO REVOKE: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed on the Notice of Privacy Practices. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, but that we may decline to treat your child or continue treating your child if you revoke this Consent.

SIGNATURE: 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 child's protected health information to carry out treatment, payment activities, and healthcare operations.

_____ _____/_____/_____

Signature of Patient Date

If this acknowledgement and Consent is signed by a parent/legal guardian/personal representative on behalf of the patient, please complete the following:

Parent/Legal Guardian/Representative's Name: _____

Signature of Parent/Legal Guardian/Representative: _____

Relationship to Client: _____

Date: _____/_____/_____

REVOCATION OF CONSENT

I revoke my child's Consent for your use and disclosure of my child's protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of this Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat my child after I have revoked this Consent.

Signature: _____ Date: _____/_____/_____

**You are entitled to a copy of this consent after you sign it. This form will be retained in your dental record.