HAASDENTAL ASSOCIATES

Child's Name_____Age_____yrs.____mos.____Date of Birth_____

Mother's Name_____

Father's Name_____

Names and dates of birth of brother and sisters _____

Child's Pediatrician or Family Practice Physician_____

Whom may we thank for referring you?_____

In order to get to know your child better, we would appreciate your taking the time to provide the following information.

FEEDING HISTORY:

Breast Fed: Totally: Yes / No How Long:_____mos. Schedule Frequency:_____.

On Demand Feeding (circle): Yes / No Through the night feeding(circle): Yes / No

Supplemental bottle began at_____months Weaned at_____months

Bottle Fed: Ready-to-feed formula: Yes / No Formula reconstituted with water (circle): Well City Bottled Water

Child has bottle in bed: Yes / No Bottle Contents_____

Still using nursing bottle: Yes / No Age discontinued nursing bottle:_____

MATERNAL-PRENATAL HISTORY:

1. Did you have a normal pregnancy? Yes / No If not, please explain:_____.
2. Did you experience any of the following during pregnancy?

Severe morning sickness: Yes / No Physical trauma or injury: Yes / No Illness: Yes / No

Took medications, antibiotics, etc: Yes / No Please specify:_____.

BIRTH HISTORY:

Full term: Yes / No Premature birth by _____weeks

Normal delivery: Yes / No Forceps delivery: Yes / No Cesarean delivery: Yes / No

Complications during delivery: Please explain:_____.

Birth Weight:_____lbs_____ozs. Birth Length_____inches

NEONATAL HISTORY [Birth to 1 month]:

Did your infant experience any of the following during the first few weeks of life?

Jaundice: Yes / No High fevers: Yes / No Breathing difficulties: Yes / No
Feeding difficulties: Yes / No Serious Illness: Yes / No Intubation: Yes / No

Comments:_____.

CHILD'S MEDICAL HISTORY:

Recent Physical Exam (approximate date): _____.

Does your child have or had [please circle]:

General Anesthesia	Asthma	Cancer	Tonsil or Adenoid Trouble
Circulatory Problems	Rheumatic Fever	Seizures	Earaches
Breathing Problems	Epilepsy	Bleeding Disorder	Ear Tubes
Eczema	Hepatitis	Lyme Disease	High Fevers
Heart Murmur	Mental Retardation	Diabetes	Anemia
Blood transfusion	Behavioral Concerns	Brain Damage	Rheumatoid Arthritis
Venereal Disease	Downs Syndrome	Abnormal Bruising	None of these conditions
HIV	Developmentally Delayed	Kidney Disease	Other: _____.
A.I.D.S.	Autism	Liver Disease	
ARC [AIDS Related Complex]	Cerebral Palsy	Jaw Trauma	

Allergies or allergic reactions: None / Yes If yes, please specify: _____.

Is your child **in good health**?: Yes / No If not, describe condition: _____.

Has your child **had a hospital admission**?: Yes / No If yes, why? : _____.

Has your child **had any major trauma**? Yes / No If yes, describe: _____.

Has your child **had surgery** /operations?: Yes / No If yes, describe: _____.

Does your child have **any limitations to physical activities**?: Yes / No If yes, describe: _____.

Is your child **currently on medication**?: Yes / No If yes, please list: _____.

Has your child been **on medication in the past**?: Yes / No If yes, please list: _____.

Has your child ever had **penicillin**?: Yes / No

Has your child ever had a reaction to **penicillin?:** None / Yes If yes, describe reaction: _____.

Has your child ever had **cortisone**?: Yes / No Had a reaction to cortisone?: None / Yes If yes, describe reaction: _____.

Has your child ever had a **reaction to other medications**? List Medication: _____Describe reaction: _____.

Current immunizations, check those your child has received:

DPT #1 [2mos.] _____	HIB # 1[2 mos.] _____	Polio [2mos.] _____	Hepatitis B [at birth] _____.
DPT #2 [4 mos.]_____	HIB #2 [4 mos.] _____	Polio [4 mos.] _____	Hepatitis B [1 mos.] _____.
DPT #3 [6mos.]_____	HIB #3 [6 mos.] _____	Polio [18mos.]_____	Hepatitis B [6 mos.] _____.
DPT #4 [18 mos.]____	HIB #4 [15 mos.] _____.		Measles, Mumps, Rubella [15 mos.]_____

Is there **additional medical information** we should know? _____.

CHILD'S DENTAL HISTORY:

Is this your child's **first visit to a dentist**?: Yes / No If not, dentist's name: _____.

Reason for seeking dental care: _____.

Do you have fluoridated water?: Yes / No / Unknown Do you **have or use**: Well / City / Bottled Water

Is your child **taking fluoride tablets or drops now**?: Yes / No / Taken in the past

Is your child **taking vitamins with fluoride now**?: Yes / No / Taken in the past

Please name your child's **three favorite snacks**: _____.

Thumb sucking: Never did / Does now / Stopped Stopped at approximately what age_____

Finger sucking: Never did / Does now / Stopped Stopped at approximately what age_____

Use of a pacifier: Never did / Does now / Stopped Stopped at approximately what age_____

Circle if your child has or had:

Dental decay	Abscess [gum boil]	Cold Sores [fever blisters]	Injury to front teeth
Discolored front teeth	Toothaches	Bad breath	Stained teeth
Clenching Teeth	Grinding teeth	Mouth breathing	Collects food between teeth
Neck swelling	Facial swelling	Mouth odor	Bleeding gums

Signature_____**Relationship to patient** _____ **Date** _____.

Haas Dental Associates

Dental Insurance Information

(*Scan Form if Card Not Available*)

___ New Ins (replaces what is currently on file for subscriber)

or

___ Additional (in addition to what is currently on file for the subscriber)

Today's Date: _____ Haas Dental Account #: _____

Subscriber Name & DOB: _____ _____

Subscriber SSN: _____

Patient Name & DOB: _____ _____

Insurance Co:_____ Delta or BC/BS State:_____

Insured ID #:_____ Insurance Group #:_____

Insurance Co Provider Phone Number: _____

Insurance Co Address: _____

Subscriber Employer Name: _____

Notes: _____

_____

HAASDENTAL
ASSOCIATES

Scheduling of Appointments

We make every attempt to arrange appointment times that are convenient: however, your flexibility and cooperation are greatly appreciated. Certain dental procedures need to be scheduled at specific times during the day. Appointments are made in your best interest with your treatment plan in mind.

Haas Dental reserves time on the schedule for each patient. When appointments are cancelled, it impacts the overall quality of service we are able to provide. **We follow a strict cancellation/no shows policy! Without 48 hours notice may result in termination from the practice.** A fee of $25/$50 may be applied. To maintain the utmost service and care, we appreciate a 48 hour notice when cancelling appointments. Patients arriving late for their appointments may be rescheduled as a courtesy to our other scheduled patients.

- To reserve an appointment time for treatment of $1000 or more, or for appointments that are over 60 minutes long, a deposit of 50% of your estimated out of pocket expense is required to reserve the chair time. If an appointment is cancelled or rescheduled less than 48 hours prior to appointment the deposit will be non-refundable.

Payment for Services

Payment is due at the time services are rendered. Any balance that is left unpaid for 30 days will be subject to interest charges. Any unpaid amount for 90 days may be referred to a collection company. A $20 charge for each returned check will apply. For your convenience, we accept the following forms of payment: Cash, Check, Credit Card and Care Credit. In the situation of divorce or separated parents, the responsible party on the ACCOUNT is responsible for costs incurred during a child's dental treatment we cannot send statements to other people. Haas Dental Associates will not become involved with or responsible for employer sponsored tax deferred flexible benefits programs. We will be happy to provide necessary documentation for such benefits upon request.

Dental Benefit Plans/Insurance

As a courtesy we will bill your insurance company. Insurance companies are not financially responsible for treatment received. Benefits estimated are not a guarantee of payment. When an insurance company is billed and has not responded within 60 days, the amount billed is the insured's responsibility. It is your responsibility to fully understand your insurance benefits and to pay all balances remaining after insurance has considered, or if you're insurance denies payment. I understand that I am responsible for payment for services rendered, regardless of estimated insurance benefits.

Authorizations

I understand that the information I have given today is correct to the best of my knowledge. I authorize Haas Dental Associates to perform necessary dental services that they deem necessary for myself or child. I understand that the expected result of said treatment cannot always be guaranteed. I understand that during the course of treatment, certain unforeseen conditions may be revealed that may necessitate extension or change from any previous treatment plans that may result in additional fees.

I have read the above and agree to the financial and scheduling terms.

- I authorize the release of information necessary to process my benefit claims and authorize payment directly to Haas Dental Associates otherwise payable to me.
- I hereby acknowledge that a copy of Haas Dental Associates' Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.
- I hereby acknowledge that a copy of Haas Dental Associates' Dental Materials Fact Sheet has been made available to me. I have been giving the opportunity to ask any questions I may have regarding the Fact Sheet.
- I authorize release of any information relating to insurance claims submitted on my behalf of my dependents. I hereby authorize payment of the dental benefits otherwise payable to me, to Haas Dental Associates.

We thank you for your cooperation and hope that any questions or concerns will be brought to our attention immediately so that we may act promptly in order to assure that your interaction with us is as pleasant as possible.

I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT. ***All information provided is kept private and used for insurance or billing purposes only.***

Print name of responsible party _____ DOB: _____

SS# ___ - ___ - ___ Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Email: _____

_____ _____ _____

Signature of Responsible Party Date Patient/s Name/s

HAAS DENTAL ASSOCIATES

Disclosure and Authorization Form

Purpose:

For you to authorize the disclosure of your personal information, which may include health information, to persons or organizations outside of Haas Dental Associates. Your privacy is protected by state and federal privacy laws. As such, we need your explicit permission to make the requested disclosure. Please complete each section of this form.

Legal Guardian Name and Identification Information:

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (___) _____ Last 4 Digits of SS#: _____

To whom are we authorized to disclose your personal information for patient: _____?

Please state the names of the individuals or organizations, including contact information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Expiration Date or Event:

This authorization will remain in effect until you notify us, in writing, that you would like to revoke this authorization.

Right to Revoke:

You have the right to revoke this authorization at any time. You may revoke this authorization by giving written notice to Haas Dental Associates. Any disclosures of your person information, which we may have made under this authorization prior to revocation, will not be affected since they were made while this authorization was still in effect.

Further Disclosure:

Once we disclose your personal information, including health information, to the above persons or organizations, the information may no longer be protected under state or federal privacy laws. We cannot control what these persons or organizations do with your information.

Signature:

Having had full opportunity to read and consider the contents of this authorization, including my rights and the risks of further disclosure as described above, I authorize Haas Dental Associates to disclose my personal information, including health information, to the persons or organizations I have identified above. I understand that Haas Dental Associates will disclose only that information which is necessary to accomplish the stated purpose of the authorization. The information disclosed will be limited to the minimum necessary. I understand that I am under no obligation to sign this authorization. I also understand that the services and benefits provided to me by or through Haas Dental Associates will not be affected whether or not I sign this form.

Signature: _____ Date: _____

To revoke this authorization, please contact:

Haas Dental Associates Attention: HIPAA Compliance, 4 Manchester Ave, Derry NH, 03038