Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

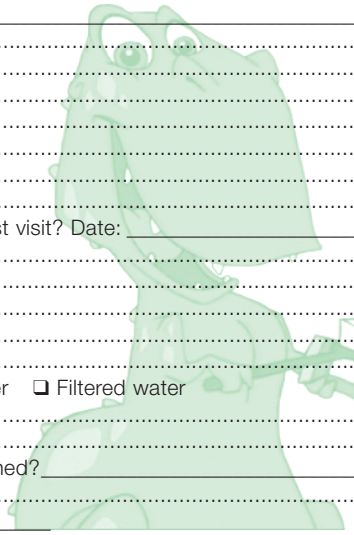
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

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: _____

_____

SPECIAL CONSENT AND RELEASE FOR TREATMENT

I hereby authorize the doctors of Haas Dental Associates (James B. Haas, D.D.S) and such assistants and associates as may be designated, to perform dental treatment and any other related procedures or forms of treatment, including appropriate anesthesia, or analgesia they may deem necessary.

I consent to the dental examination, x-rays, consultation and treatment by Dr, Haas, associates and/or assistants.

I understand that the expected results of said treatment cannot always be guaranteed.

Drs. Haas, associates, and/or his auxiliaries have discussed to my satisfaction the following:

1. **The nature and character of the proposed treatment/procedure.**
2. **The anticipated results of the proposed treatment/procedure.**
3. **The recognized alternative forms of treatment/procedure.**
4. **The recognized serious possible risks and complications of the treatment/procedure, including non-treatment.**
5. **The anticipated date and time of the proposed treatment/procedure.**
6. **That Dr. Haas is a Board Certified specialist in Pediatric Dentistry.**

Drs. Haas and / or associates have offered to answer all inquiries concerning the proposed treatment/procedure. I understand that I am free to withhold or withdraw consent to the proposed treatment/procedure at any time.

I have been informed of complications and risks involved in procedures to be performed and acknowledge that my questions regarding said risks/complications have been answered to my satisfaction.

I understand that no treatment will be performed until this consent has been executed and that it will be permanently filed in the patient's dental record.

Signature _____

HAASDENTAL
ASSOCIATES
Pediatric Dentistry | Orthodontics

Informed consent tooth colored composite fillings.

What is a composite Resin (Tooth colored Filling)?

A composite resin is a tooth-colored plastic mixture filled with (silicon dioxide). First introduced in the 1960's dental composites were confined to the front teeth because they were not strong enough to withstand the pressure generated by the back teeth. Since then, composites have been significantly improved and can be successfully placed in the back teeth as well. Studies have now shown that composites have strength, durability, and longevity comparable to silver fillings. Esthetics are far superior over silver fillings. The dentist can blend shades to create a color nearly identical to that of the actual tooth. Composites also bond to the tooth to support the remaining tooth structure, which helps to prevent breakage and insulate the tooth from excessive temperature changes.

Our office only places composite resin (tooth colored) fillings. Please note, most dental insurance plans do not cover the entire cost of the composite fillings. This may result with the patient responsible for paying a modest balance. If you have any questions regarding your individual insurance coverage we recommend you review you insurance policy book prior to your appointment.

Informed consent New Patient Initial Examination

Radiographic (x-ray) policy

Please be advised that all new patients will have a full set of radiographs (x-rays) consisting of 18 individual x-rays or a panoramic radiograph (x-ray that foes around the head) and several individual x-rays. These x-rays are an integral part of our examination and evaluation of your teeth and surrounding bone. If you have had these x-rays taken within the past 3 years at a previous dentist it is your responsibility to either bring a copy of them with you to you examination or have them sent to our office prior to your visit. Without these preexisting x-rays we will be unable to properly diagnose any dental or periodontal (gum/bone) problems you may have. If necessary we can take a new full set of x-rays here, however, if you have dental insurance (if less than 3 years) they will likely not cover it.

I certify that I have read the above information regarding composite resin tooth colored fillings, and recognize that if my insurance does not pay for tooth colored restorations that I am responsible for the balance. I certify that I have also read and understand the information regarding dental x-rays and new patient exam.

Patient Signature_____ Date_____

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