Playtime Dental
JACKSON COCKLEY DDS
GENERAL DENTIST

Patient Information

Patient Name: _____, _____ ____ _____
Patient Last Name Patient First Name MI Preferred

Male _____ Female _____ Family Status: Married ____ Single _____ Child _____

_____ _____ _____
Birthdate Social Security Number e-mail address

_____ _____ _____ _____
Home address City State Zip

_____ _____ _____ _____
School Grade Home phone Cell

Whom may we thank for referring you to our practice?

Playtime Dental Website Facebook Google Internet Explorer (Bing) Flyer by Mail

Newspaper Radio School Sign on Trimble Road Phonebook other (name below)

Name of person, office or other source referring you to our practice: _____.

If you heard of us from somewhere other than the internet, did you research us online too? Yes or No
-If yes, please circle all that apply. Playtime Dental Website Facebook Google Internet Explorer (Bing)

Patient Health History

Please circle "Y" for yes or "N" for no

Y/N ADHD/ADD	N/Y Alcohol/Drug Use	Y/N Allergies	N/Y Allergy – Latex
N/Y Allergy – Seasonal	Y/N Anemia	N/Y Arthritis	Y/N Artificial Joints
Y/N Asthma	N/Y Autism	Y/N Birth Defects	N/Y Blood Disease
N/Y Cancer	Y/N Diabetes	N/Y Disability/Sp.Need	Y/N Dizziness
Y/N Epilepsy	N/Y Excessive Bleeding	Y/N Fainting	N/Y Glaucoma
N/Y Head Injuries	Y/N Heart Disease	N/Y Heart Murmur	Y/N Hepatitis
Y/N High Blood Pressure	N/Y HIV/AIDS	Y/N Jaundice	N/Y Kidney Disease
N/Y Liver Disease	Y/N Mental Disorders	N/Y Nervous Disorders	Y/N Other
Y/N Pacemaker	N/Y Pregnancy	Y/N Radiation Treatment	N/Y Respiratory Prob
N/Y Rheumatic Fever	Y/N Sickle Cell Anemia	N/Y Sinus Problems	Y/N Smoking
Y/N Speech/Hearing Prob	N/Y Stomach Problems	Y/N Stroke	N/Y Tobacco Use
N/Y Tuberculosis	Y/N Tumors	N/Y Ulcers	Y/N Scarlet Fever
Y/N Use of Diet Pills	N/Y Venereal Disease		

If you circled "Y" for any of the above, please explain: _____

_____.

Does the Patient have any other health problems not listed? _____ if yes, please explain: _____.

Has the patient had any type of surgery? _____ if yes, please explain: _____.

Has the patient had his or her tonsils removed? YES NO

Has the patient had his or her adenoids removed? YES NO

Does the patient have environmental (Seasonal) allergies? YES NO

Is the patient taking any medications at this time (including over-the-counter medications such as aspirin)? _____ If yes, what type? _____

Does the patient's physician prescribe vitamins with fluoride? _____

Do you give your baby powdered formula? (Circle) YES NO N/A

Do you have well water or city water? (Circle) WELL CITY
-What city do you pay your water bill _____ / Don't know

Would you like to have a prescription for fluoride for the patient? _____

Is the patient allergic to any medications? _____ If yes, what? _____

Is the patient allergic to anything else? _____ If yes, what? (sample: latex, anesthesia) _____

_____.

Does the patient have any dental problems/concerns at this time? _____ If yes, please explain:

_____.

Preferred language _____ Race _____ Ethnicity _____

- *Has the patient ever been seen by the Mobile Dentist at school? Yes or No When**?*** _____

Pharmacy of Choice

Name and phone number of pharmacy: _____

Pursuant to an agreement with the Office of Inspector General of the United States Department of Health and Human Services, this dental office maintains a list of substantiated incidents of patient harm over the last eighteen months, which is available for our review upon request. I verify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.
I consent for the examination, teeth cleaning, application of topical fluoride, any necessary x-rays and clinical photographs, and any necessary sealants.

Signature: _____ Date: _____

Is the person completing this form authorized to consent to dental treatment? Yes or No

Will anyone <u>other than yourself</u> (this includes the child's other parent, grandparent, aunt, uncle, friend, etc.) be bringing this patient to our office for treatment? Yes or *No or N/A*

**Note: If "Yes" is answered in the above question please fill out the Authorization of Persons form. If the form is NOT filled out and somebody else brings the patient, such as the patient's other parent, we will NOT see the patient.

Please circle <u>Y</u>es or <u>N</u>o for each habit as it applies to this patient.

ORAL HABITS

Y / N Thumb sucking
Y / N Finger sucking
Y / N Lip sucking
Y / N Tongue sucking
Y / N Fingernail biting
Y / N Chewing cheek
Y / N Clenches teeth
Y / N Grinds teeth
Y / N Pacifier

DIETARY HABITS

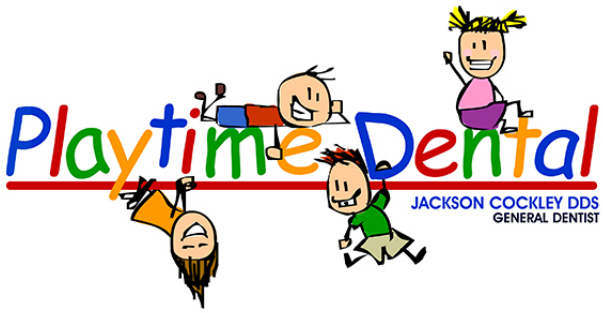
Y / N Uses a sippy cup
Y / N Takes a bottle
Y / N Takes a bottle to bed
Y / N Soda pop: How many per day? _____
Y / N Juice: When? With meals or between meals or both
Y / N Milk: When? With meals or between meals or both
Y / N Water: When? With meals or between meals or both
Y / N Sugar-free beverages: When? With meals or between meals or both
Y / N Sports drinks: When? With meals or between meals or both
Y / N Candy
Y / N Snacks between meals

BRUSHING HABITS

Y / N Patient brushes teeth by himself / herself
Y / N An adult brushes patient's teeth
Y / N An adult brushes patient's teeth after patient brushes
>>→ **Patient brushes how many times in a day?** _____
Y / N Patient and/or adult brushes teeth after breakfast?
Y / N Patient and/or adult brushes teeth before bedtime?
Y / N Patient's teeth are flossed; If "Yes", how often? _____
Y / N Do Patient's gums bleed when brushed?

ORTHODONTICS <u>**Please fill out if you are interested in orthodontics</u>

Y / N Have there been any injuries to face, mouth, or teeth? _____
Y / N Have you ever seen an orthodontist? If yes, who and when? _____
What is your attitude toward receiving orthodontic treatment? _____
Y / N Has anyone in your family received orthodontic treatment? _____
How did they feel about the results? _____
Y / N Are you aware of your jaw clicking or popping? _____



PARENT/GUARDIAN OR RESPONSIBLE PARTY

NAME: _____, _____ _____ _____
Last First MI Preferred Name

Title: _____ Gender: Male _____ Female _____

Family Status: Married _____ Single _____ Other _____

_____ _____ _____
Birthdate Social Security Number e-mail address

_____ _____ _____ _____ _____
Home phone Work phone Ext Cell phone Best time to call

_____ _____ _____ _____
Home address City State Zip

EMPLOYMENT INFORMATION

The following is for the patient_____ or the person responsible for payment _____

Employer name: _____ Phone: _____

Employer address: _____

PRIMARY INSURANCE INFORMATION

Name of insured: _____

Patient's relationship to insured: Self _____ Spouse _____ Child _____ Other _____

Insurance Plan Name: _____

SECONDARY INSURANCE INFORMATION

Name of insured: _____

Patient's relationship to insured: Self _____ Spouse _____ Child _____ Other _____

Insurance Plan Name: _____

CONSENT FOR SERVICES

As a condition of treatment by this office, financial arrangements (i.e. insurance plan or advanced payment) must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment (verifying insurance).

All emergency dental services or any dental services performed without previous financial arrangements (i.e. no insurance), must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services, if applicable. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges if no insurance, or out of network coverage, for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee to telephone me to discuss this statement or my treatment.

Cockley's Playtime Dental, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

I have read the above conditions of treatment and payment and agree to their content.

_____	_____	_____
Signature	Date	Relationship to Patient

PLEASE NOTE:

After 3 broken appointments for your family, we can no longer schedule any appointments.