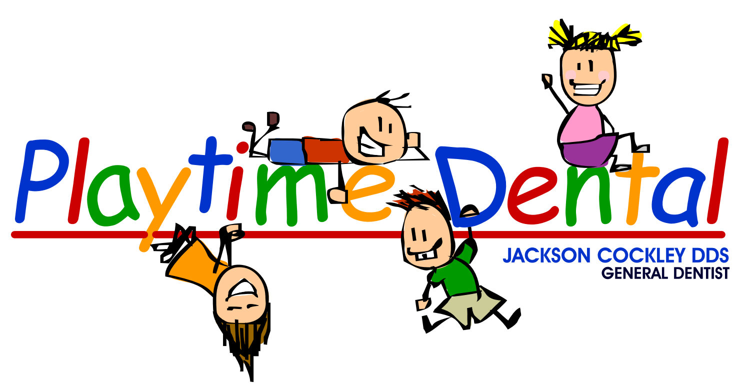


PATIENT INFORMATION

Patient Name:

patient last name | patient first name | middle initial | preferred name

Male: ☐ Female: ☐ Family Status: married ☐ single ☐ child ☐

birth date | social security number | email address

home address | city | state | zip

school | grade | home phone | cell phone

If this is your first visit, whom may we thank for referring you to our practice? Please check.

- ☐ playtime dental website
- ☐ facebook
- ☐ event (please name) ________
- ☐ google review
- ☐ internet (other)
- ☐ existing patient (please name) ________
- ☐ flyer by mail
- ☐ school
- ☐ another dentist's office (please name) ________
- ☐ sign on trimble road

If you heard of us from somewhere other than the internet, did you research us online too? yes ☐ no ☐

Patient Health History: please check all that apply

☐ ADHD/ADD	☐ alcohol/drug use	☐ allergies	☐ allergy - latex
☐ allergy – seasonal	☐ anemia	☐ arthritis	☐ artificial joints
☐ asthma	☐ autism	☐ birth defects	☐ blood disease
☐ cancer	☐ diabetes	☐ disability/special needs	☐ dizziness
☐ epilepsy	☐ excessive bleeding	☐ fainting	☐ glaucoma
☐ head injuries	☐ heart disease	☐ heart murmur	☐ hepatitis
☐ high blood pressure	☐ HIV/AIDS	☐ jaundice	☐ kidney disease
☐ liver disease	☐ mental disorder	☐ nervous disorders	☐ other
☐ pacemaker	☐ pregnancy	☐ radiation treatment	☐ respiratory problem
☐ rheumatic fever	☐ sickle cell anemia	☐ sinus problems	☐ smoking
☐ speech/hearing prob.	☐ stomach problems	☐ stroke	☐ tobacco use
☐ tuberculosis	☐ tumors	☐ ulcers	☐ scarlet fever
☐ use of diet pills	☐ venereal disease		

If you checked any of the above, please explain:

Does the patient have any other health problems not listed? yes ☐ no ☐ If yes, please explain:

Has the patient had any type of surgery? yes ☐ no ☐ If yes, please explain:

Has your child had his or her tonsils removed? yes ☐ no ☐

Has your child had his or her adenoids removed? yes ☐ no ☐

Does your child have environmental (Seasonal) allergies? yes ☐ no ☐

Is the patient taking any medications at this time
(including over-the-counter medications such as aspirin)? yes ☐ no ☐

If yes, what type?:

Does the patient's physician prescribe vitamins with fluoride? yes ☐ no ☐

Do you give your baby powdered formula? yes ☐ no ☐ n/a ☐

Do you have well water or city water? well ☐ city ☐

What city do you pay your water bill? ☐ check here if you do not know

Would you like to have a prescription for fluoride for the patient? yes ☐ no ☐

Is the patient allergic to any medications? yes ☐ no ☐
If yes, what?:

Is the patient allergic to anything else? yes ☐ no ☐
If yes, what (examples - latex, anesthesia)?:

Does the patient have any dental problems/concerns at this time? yes ☐ no ☐ If yes, please explain:

Preferred language: ______ Race: ______ Ethnicity: ______

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 ☐ no ☐

Will anyone other than yourself (this includes the child's other parent, grandparent, aunt, uncle, friend, etc.) be bringing this patient to our office for treatment? yes ☐ no ☐

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 check Yes or No for each habit as it applies to this patient:

ORAL HABITS:

thumb sucking	yes ☐	no ☐
finger sucking	yes ☐	no ☐
lip sucking	yes ☐	no ☐
tongue sucking	yes ☐	no ☐
fingernail biting	yes ☐	no ☐
chewing cheek	yes ☐	no ☐
clenches teeth	yes ☐	no ☐
grinds teeth	yes ☐	no ☐
pacifier	yes ☐	no ☐

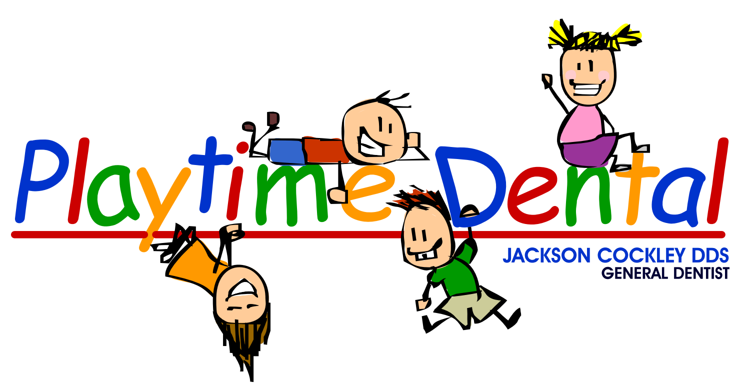
BRUSHING HABITS:

Patient brushes teeth by himself / herself	yes ☐	no ☐
An adult brushes patient's teeth	yes ☐	no ☐
An adult brushes patient's teeth after patient brushes	yes ☐	no ☐
Patient brushes how many times in a day?	__________	
Patient and/or adult brushes teeth after breakfast?	yes ☐	no ☐
Patient and/or adult brushes teeth before bedtime?	yes ☐	no ☐
Patient's teeth are flossed	yes ☐	no ☐

If yes, how often? __________

DIETARY HABITS:

uses a sippy cup	yes ☐	no ☐
takes a bottle	yes ☐	no ☐
takes a bottle to bed	yes ☐	no ☐
soda pop: how many per day?	yes ☐	no ☐
juice with meals | between meals | after meals	yes ☐	no ☐
milk with meals | between meals | after meals	yes ☐	no ☐
water with meals | between meals | after meals	yes ☐	no ☐
sugar free beverages with meals | between meals | after meals	yes ☐	no ☐
sports drinks with meals | between meals | after meals	yes ☐	no ☐
candy	yes ☐	no ☐
snacks between meals	yes ☐	no ☐



PARENT/GUARDIAN OR RESPONSIBLE PARTY

last name first name middle initial preferred name

Male: ☐ Female: ☐ Family Status: married ☐ single ☐ child ☐

birth date social security number email address

home address city state zip

school grade home phone cell phone

EMPLOYMENT INFORMATION

The following information is for the patient: ☐ or the person responsible for payment: ☐

employer name: phone number

employer address:

PRIMARY INSURANCE INFORMATION

name of insured: ________

patient's relationship to the insured: self ☐ spouse: ☐ child: ☐ other: ________

insurance plan name: ________

SECONDARY INSURANCE INFORMATION

name of insured: ________

patient's relationship to the insured: self ☐ spouse: ☐ child: ☐ other: ________

insurance plan name: ________

Playtime Dental

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.