York Dental Health Associates

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(Minor child info. sheet)

Name of Minor Child:____Nick name:___________________________

Home address of child:____

Phone #:________________Child's social security #:________________Date of birth:________________________

Male or Female (please circle) Insurance Company Name (if child is also the subscriber) ______________________________

ID#:_____________________________________ Group#:____

Who is financially responsible for the child ?____

Address of responsible person: ____

Phone #s: Home________________________, Work________________________, Cell______________________

Father's name: ____, SS#_______________________

Father's date of birth:_______________ Father's address____

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Phone #s: Home_______________________, Work________________________, Cell_______________________

Father's employer:____

Name of Insurance Company (if carried on the minor by the father):____

ID#:_______________________________Group#:__________________________Primary or Secondary (please circle)

Mother's name:____, SS#:________________________

Mother's date of birth:_______________ Mother's address:____

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Phone #s Home:______________________, Work________________________, Cell________________________

Mother's employer:____

Name of Insurance Company (if carried on the minor by the mother)____

ID#_______________________________Group#__________________________Primary or Secondary (please circle)

Emergency contact :____

Whom may we thank for referring you?____

Dental History

Date of last dental visit: ___________________ what services were performed? ______________________________________

Has the child complained about any dental problems? _____ If so, what were they? ___________________________________

Is fluoride taken in any form? ________________ does the child brush daily? _____________________ Floss? _____________

Has the child ever experienced an injury to the head, mouth, and or teeth? ____

Has the child ever had an unpleasant dental experience? ____

Has the child ever had any oral habits such as; thumb sucking, nail biting, mouth breathing, pacifier, sleeping with a bottle, etc.?
____

Medical History

Physician: __________________________________Address: ____

City/State: __________________________________Phone #: ____

Date of last check-up: _________________________Currently under the care of a physician? YES/NO (please circle)

Is the child currently taking any medications? YES/NO (please circle) Medication/Drug Names:_____________________________

Has the child ever been hospitalized? YES/NO (please circle) has the child ever had surgery? YES/NO (please circle)

If yes please explain: ____

Any excessive bleeding when the child gets a cut? YES/NO (please circle) ____

Allergies: ____

Has the minor or child had any history of or difficulty with any of the following?

(please check all that apply)

____A.I.D.S./H.I.V.	____Cerebral Palsy	____Epilepsy	____Kidney Disease	____Anemia
____Asthma	____ Chicken Pox	____Fainting	____Liver Disease	____Rheumatic Fever
____Bladder Problems	____Diabetes	____Measles	____Mono	____Hearing Problems
____Convulsions	____Heart Condition	____Sinus Problems	____Cancer	____Thyroid Disease
____Tuberculosis	____Hepatitis	____Mumps	____Heart Murmur	____Drug/Alcohol Abuse

____Other (please explain) ____

Authorizations

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence. It is my responsibility to inform York Dental Health Associates of any changes to my child's personal, medical, and or insurance status. I hereby authorize the dental staff to perform the necessary dental services for my child.

____ _____________________________

Signature of Parent/Guardian Date

Payment is expected at time of service

I understand and agree that regardless of my insurance coverage I am ultimately responsible for any and all charges incurred for my child's dental treatment. I agree to pay for any unpaid balances in a timely manner. I further understand that I will be responsible for any legal fees incurred in pursuing any unpaid balances, including court costs and attorney fees. Charges that are delinquent more than 90 days may be subject to legal processing. A fee of 30% of any unpaid balance may be assessed to your balance if your account is turned over for collection or legal processing.

Notice of privacy practice

Our practice provides this notice to comply with privacy regulations now imposed on all providers. It is our policy to keep all patient information confidential. Information needed by insurance companies to process claims will be released as necessary.

Any pertinent information needed by other healthcare providers will be released as necessary to insure proper care.

____ ________________________________

Signature of Parent/Guardian Date