Hildebrand Dental

Child Information:

Child's Name: _____ Preferred Name: _____
Last Name First M.I.

□Male □Female Date of Birth: _____/_____/_____ SSN: _____/_____/_____

Home Address: _____
Street City State Zip Code

Preferred Contact Number: (_____)_____

How did you hear about us? ☐ Google ☐ Website ☐ Facebook ☐ Insurance ☐ Other ☐ Friend/Family Member

Who can we thank for referring you? _____

Parent Information:

Mother's Name: _____ Father's Name: _____

Mailing Address: _____ Mailing Address: _____

Email Address: _____ Email Address: _____

Preferred Contact Number: (_____)_____ Preferred Contact Number: (_____)_____

Dental History:

Reason for the visit today? _____ Date of last Dental visit? _____

How often do they floss? _____ How often do they brush? _____

Interested in straightening your child's teeth □Yes □No Interested in whitening your child's teeth □Yes □No

Please check if your child has/had:

Yes	No		Yes	No	
□	□	Allergic reaction to local anesthetics	□	□	Loose teeth
□	□	Bad breath	□	□	Mouth breathing/ snoring
□	□	Bad previous dental experience	□	□	Nitrous oxide used at past dental appointments
□	□	Blisters/Canker sores/Cold sores	□	□	Nursing/bottle/pacifier habits
□	□	Clench or grind teeth	□	□	Orthodontic treatment
□	□	Clicking/popping, TMJ/jaw, or head/neck pain	□	□	Sensitivity to pressure or irritants (cold/heat/sweets)
□	□	Finger/thumb sucker	□	□	Tongue or lip tied
□	□	Gums swollen, tender or bleeding	□	□	Tonsils and/or adenoids removed

Medical History:

Is child currently under a physician's care? Yes□ No□ If yes, please explain_____ Physician's name:_____

Has child ever had any serious illnesses or operation? Yes□ No□ If yes, please describe_____

List any allergies (medications): _____ Allergy to latex? Yes□ No□

List any medications or History not listed: _____

_____

Please check if your child has/had:

Yes	No		Yes	No	
□	□	Artificial joints	□	□	ADHD
□	□	Allergies, hay fever, sinus trouble	□	□	Asperger syndrome
□	□	Asthma: Date of last episode ___/___/____	□	□	Autism
□	□	Respiratory disease	□	□	Down syndrome
□	□	Cancer	□	□	Epilepsy
□	□	Chemotherapy	□	□	Sensory issues
□	□	Radiation treatment	□	□	Speech disorders
□	□	Acid reflux	□	□	Anemia
□	□	AIDS / HIV	□	□	Bleeding abnormally with operations/surgery
□	□	Cortisone treatments	□	□	Blood disease, clotting disorders
□	□	Diabetes: type ____	□	□	Blood transfusion: Approximate date ___/___/____
□	□	Fainting: When does it occur _____	□	□	Circulatory problems
□	□	Headaches: How often _____	□	□	Heart problems / heart murmur
□	□	Hepatitis (type) ____	□	□	High blood pressure: Last reading date ___/___/____
□	□	Immune deficiencies	□	□	Low blood pressure
□	□	Jaundice	□	□	Shortness of breath
□	□	Kidney disease	□	□	Swelling of feet/ankles
□	□	Thyroid problems: type ____	□	□	Weight loss/gain

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General Consent Form:

By initialing below, I give consent –

_____ for treatment by Hildebrand Dental. I am responsible for payment of all services on my behalf or my dependents. I authorize and request my insurance company (if applicable) to pay directly to Hildebrand Dental. I understand that if my dental insurance should happen to send payment to me, directly, that it is my responsibility to forward the payment to Hildebrand Dental. I understand that my dental insurance may pay less than the actual bill for services. I further understand that quotes from Hildebrand Dental are only estimates, not a guarantee of coverage and my insurance may pay more or less.

_____ for Hildebrand Dental to use photographs, radiographs and/or study models for educational or promotional purposes.

_____ for Hildebrand Dental to leave Protected Health Information on my answering machine/ voicemail.

_____ to the use and disclosure of your Protected Health Information by Hildebrand Dental, our team, and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Privacy Practices.

_____ I understand that a $25 fee will be assessed for any missed appointments or cancellations with less than 24 hour notice.

You have the right to review our Notice of Privacy Practices prior to signing this consent. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Hildebrand Dental at (816) 873-3260 or by email at hildebranddental@gmail.com or by mail at 110 Hospital Dr. Smithville, MO 64089.

You have the right to request that we restrict our uses or disclosures of your Protected Health Information which we are otherwise permitted to make for treatment, payment and health care operations, understanding that we are not required to agree to these restrictions. However, if we agree to such restrictions, they are binding on us. Finally, you may refuse to consent to the uses or disclosure of your Protected Health Information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Protected Health Information. I understand that I may obtain a copy of the Notice of Privacy Practices and revisions upon my request.

By signing this, I acknowledge that I have reviewed and answered the questions on this form to the best of my knowledge and understanding, and agree to the content of the information listed above.

Patient/Guardian signature_____ Date: ____/____/_____

Reviewed by: _____