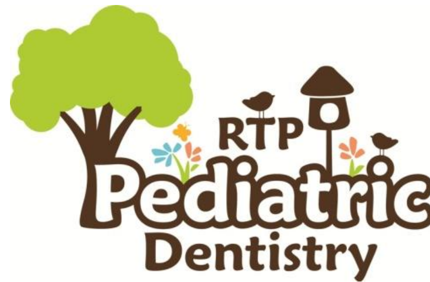
Welcome



5318 NC Hwy 55
Suite 202
Durham, NC 27713
Phone: (919) 827-1350

Health History Form

Today's Date: ______________

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name: ____
Last First Middle

Goes by: ______________________ ☐ Male ☐ Female

Child's Birth date: _____/_____/_______ Child's Age: ________

Child's Home #: (_________)_________-____________

SS#: ____

Child's Home Address: __________________________________

____

Siblings that we treat: _________________________________

2. Mother's Information

Name: ____

Birth date: ______/______/_______ SS#: ____________________

Employer: ____

Home #: (_______)________-___________ ☐ same as child

Cell #: (_______)_______-_________ ☐ okay to leave message?

Work #: (_______)________-___________ Ext: ____________

Email: ____

3. Father's Information

Name: ____

Birth date: ______/______/_______ SS#: ____________________

Employer: ____

Home #: (_______)________-___________ ☐ same as child

Cell #: (_______)_______-_________ ☐ okay to leave message?

Work #: (_______)________-___________ Ext: ____________

Email: ____

4. Appointment Reminders

Preferred Method of Contact for appointment confirmations:
(checkmark all that apply)

☐ Call home and/or cell phone

☐ Text message cell phone

☐ Email parent

5. Who is Accompanying the Child Today?

Name: ____

Relationship: ____

Do you have legal custody of this child? Yes No

6. Person Responsible for Account

☐ Mother ☐ Father ☐ Guardian

If Guardian, complete the following:

Name: ____

Relationship: _______________________________________

Billing Address: _____________________________________

____

Home #: (_______)________-_________ ☐ same as child

Cell #: (_______)_______-________ okay to leave message?

Email: ____

7. Primary Dental Insurance

Insurance Co. Name: _______________________________

Insurance Co. Phone: (_________)_________-___________

ID #: ____

Group/Plan #: _______________________________________

Policy Owner: _______________________________________

Birth date: ______/_____/_____ SS#: __________________

Employer: ____

8. Secondary Dental Insurance

Insurance Co. Name: _______________________________

Insurance Co. Phone: (_________)_________-___________

ID #: ____

Group/Plan #: _______________________________________

Policy Owner: _______________________________________

Birth date: ______/_____/_____ SS#: __________________

Employer: ____

9. Dental History

Is this your child's first visit to the dentist? ___________________

If not, how long since the last visit? _________________________

Previous Dentist's Name: ________________________________

Were any x-rays taken at previous dental visits? ______________

Have there been any injuries to the teeth, face, or mouth? _______

If yes, please explain: _______________________________________

____

____

Why did you bring your child to the dentist today? _____________

____

____

Does the child have any of the following habits?

Y	N	Nursing/Bottle Habits	Y	N	Nail Biting
Y	N	Lip Sucking/Biting	Y	N	Thumb/Finger Sucking

Has your child ever had a serious or difficult problem associated with previous dental work? ________________________

If yes, please explain: _______________________________________

____

____

Is your child's water fluoridated?	Yes	No
Is the child taking fluoride supplements?	Yes	No
Has the child ever had any pain/tenderness in his/her jaw (TMJ/TMD)?	Yes	No
Does your child brush his/her teeth daily?	Yes	No
Does your child floss his/her teeth daily?	Yes	No

10. Health History

Has your child ever had any of the following conditions?

Y	N	Abnormal Bleeding	Y	N	Disabilities/Special Needs
Y	N	Allergies to any Drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Disease/Murmur
Y	N	Any Operations	Y	N	Hemophilia/Blood Disorders
Y	N	Asthma	Y	N	Hepatitis
Y	N	Cancer	Y	N	HIV/AIDS
Y	N	Congenital Birth Defects	Y	N	Kidney/Liver Conditions
Y	N	Convulsions/Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Pregnancy	Y	N	Allergies to Latex
Y	N	Tuberculosis	Y	N	Diabetes
Y	N	ADD/ADHD	Y	N	Autism

Please discuss any serious medical conditions your child has had:

____

____

Please list all drugs your child is currently taking: _____________

____

____

Please list all allergies: ________________________________

____

Child's Physician: _______________________________________

Phone #: (_______)________-___________

Is your child currently under the care of a physician? Yes No

Please describe your child's current physical health:

Good ☐ Fair ☐ Poor ☐

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I request and authorize Dr. Wang to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. wang to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Wang will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice.

I authorize RTP Pediatric Dentistry to file treatments to my insurance company on my behalf as a courtesy. I understand and agree that estimated insurance payments are only an estimate. I understand that RTP Pediatric Dentistry is not responsible for knowing the status or details of my insurance coverage. The specific details of my policy is MY responsibility and I will be billed and held responsible for services not reimbursed by my insurance company.

____ ____________________________

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Dr Initials: _____________ Date: _______________

Dr's Comments: ________________________________

____

Appointment Policy

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call the office **at least 48 hours** in advance so that we may give that time to another patient.

- All restorative (fillings, extractions, etc.) procedures are scheduled in the morning. Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
- We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your appointment. We will do the exact same if your child is in need of emergency treatment.
- Please plan to arrive 10 minutes **before** your scheduled appointment. This will allow time for parking and to complete any additional paperwork so we can see your child on time.
- If you arrive over 15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.
- Again, please call at least 48 hours in advance if a cancellation is unavoidable so that we may give it to another patient.
- If you miss an appointment or cancel within 24 hours, we have the right to charge a **$50.00** broken appointment fee. If two (2) missed appointments occur or two (2) cancellations without 24-hour notice, our office reserves the right to NOT schedule any subsequent appointments.
- A parent (or legal guardian with official documentation) must be present during all appointments that the patient is in the office.

If at any time you have questions, please feel free to ask our front office staff. We are here to help in any way we can. We appreciate you entrusting us with your child's dental health.

Thank you!

Patient Name: ______________________________________

Parent/Guardian Signature: ______________________________________ Date: __________

Payment Policy

Please be aware that the parent/guardian bringing the child to our office is legally responsible for payment of all charges at the time of service. We cannot send statements to other persons. We accept cash, personal check, MasterCard, Visa or Discover.

Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following alternatives are listed as a guide for possible financial arrangements:

- **Payment in full** for each appointment as services are rendered. If you have not paid in full or arranged and honored a payment plan within two (2) months, we will refer your account to a collection agency. They, in turn, will report your past due status to a credit reporting agency. Any fees incurred by RTP Pediatric Dentistry for attorney or court costs will be your responsibility.

- **Dental Insurance**: There is no direct relationship between our office and your insurance company. Your insurance benefits are determined by the type of plan chosen by you and/or your employer. As such, we have no control over the terms of your contract, the method of reimbursement, or the determination of your insurance benefits. Therefore**,** *we do not accept assignment of benefits from all insurance companies*.* As a courtesy to you, we will submit all procedures to your insurance company. However, because we are a specialist, they may send the reimbursement check to your home address, leaving you responsible for the patient's account balance.

  Pre-treatment Authorization: Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with treatment before the insurance benefit is determined.

- **Appliances:** The cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the lab bills when appliances are ordered, not when they are completed.

- **Emergency treatment**: *All* emergency treatment must be paid in full at the time the service is rendered.

There may be special circumstances in which we accept assignment of benefits from your insurance company, but please remember, even if you have insurance coverage,* ***you are responsible for payment of your account.* *Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. You are helping to keep our overhead expenses, in the form of direct and labor costs, down. In addition, you are helping keep your fees as low as possible. If you have any questions, please feel free to ask one of our front office staff.*

Thank you!

Parent/Guardian Signature: ____ Date: ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

____

Please Print Your Name Here

____

Signature

____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other (*Please provide specific details*)

____

____

____

____

______________________________________ ______________________

Employee Signature *Date*

This form does not constitute legal advice and covers only federal, not state, law.