



Thank you for selecting our team for your dental care. We are pleased to welcome you to our practice! To help us better serve you and meet your dental healthcare needs, please complete the following forms. If you have any questions or need assistance, please ask us, we are always happy to help in anyway possible!

YOUR CHILD'S PERSONAL INFORMATION

Date: _____

Child's Name: _____ MI: _____ Last Name: _____

Sex: Female Male Birthdate: _____

Wishes to be called: _____ SSN: _____

Address: _____

City: _____ State/Zip: _____

How did you hear about us? _____

RESPONSIBLE PARTY (Person responsible for Child's Account)

Name: _____

Relationship to patient: _____

Birthdate: _____ SSN: _____

Address: _____

City: _____ State/Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State/Zip: _____

RESPONSIBLE PARTY (Person responsible for Scheduling Appointments)

Name: _____

Relationship to patient: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Best way for us to reach you? (please circle) Home Work Cell Email

If by phone, preferred date and time?: _____

MOTHER STEPMOTHER GUARDIAN

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. # _____

Email _____

Employer _____ Occupation _____

SSN: _____

Status: Single Married Divorced
 Widowed Separated

FATHER STEPFATHER GUARDIAN

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. # _____

Email _____

Employer _____ Occupation _____

SSN: _____

Status: Single Married Divorced
 Widowed Separated

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

SECONDARY INSURANCE

Name of Subscriber: _____

Relationship to Patient: _____

Subscriber's Birthdate: _____

Subscriber's Address: _____

Subscriber's SSN: _____

Subscriber's Employer: _____

Insurance Co: _____

Group #: _____

Insurance Co Phone #: _____

Name of Subscriber: _____

Relationship to Patient: _____

Subscriber's Birthdate: _____

Subscriber's Address: _____

Subscriber's SSN: _____

Subscriber's Employer: _____

Insurance Co: _____

Group #: _____

Insurance Co Phone #: _____

AUTHORIZATION AND RELEASE

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Furthermore, I authorize the assignment of benefits to be paid directly to F. R. Dahm D.D.S., P.L.L.C dba Fred Dahm Dentistry.

Signature of Parent/Guardian

Date

Thank you for taking the time to complete this form in its entirety. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask us, we are always happy to help!



PATIENT/CHILD NAME _____

DATE: _____

DENTAL HISTORY (Please answer Yes or No to the following questions)

Chief Dental Concern for your Child: _____

Is this your child's first dental visit? Yes No

Previous Dentist's Name: _____

Date of last visit: _____

Does your child feel nervous about having dental treatment? Yes No

Has your child ever had a bad dental experience? Yes No

If yes, please explain: _____

Has your child been seen by an Orthodontist? Yes No

Have there been any injuries to your child's teeth or jaw?
(Falls, Blows, Chips, etc.) Yes No

Has your child ever been premedicated for dental work? Yes No

How often does your child brush? _____ Floss? _____

Does your child receive fluoride in vitamins, tablets, or water? Yes No

HEALTH HISTORY (Please answer Yes or No to the following questions)

Is your child having any pain or discomfort at this time? Yes No

Is your child currently taking any medications? Yes No

If Yes, please list:

Has your child been hospitalized during the past 2 years? Yes No

If Yes, please explain: _____

Has your child been under the care of a medical doctor during the past 2 yrs? Yes No

Physician Name: _____

Physician's Number: _____

Has your child taken any medicine/drugs during the past 2 years? Yes No

If yes, please list: _____

Please list any serious medical condition(s) that your child has or has had: _____

MEDICAL CONDITIONS (Please answer Yes or No to the following conditions)

	Y	N		Y	N		Y	N
Allergies			Epilepsy			Radiation Treatment		
Allergy - Hay Fever			Excessive Bleeding			Respiratory Problems		
Allergy - Penicillin			Fainting			Rheumatic Fever		
Allergy - Erythro			Fever Blisters/Cold Sores			Rheumatism		
Allergy - Sulfa			Frequent Headaches			Shingles		
Anemia			Glaucoma			Sickle Cell Disease		
Angina Pectoris			Head Injuries			Sinus Problems		
Anxiety/Depression			Heart Attack			Stomach Problems		
Arthritis			Heart Disease			Stroke		
Artificial Heart Valve			Heart Failure			Thyroid Disease		
Artificial Joints			Heart Murmur			Tuberculosis		
Asthma			Heart Surgery			Tumors		
Blood Disease			Hemophilia			Ulcers		
Blood Transfusion			Hepatitis			Venereal Disease		
Bruise Easily			High/Low Blood Pressure			X-ray/Cobalt Treatment		
Cancer			HIV/Aids					
Congenital Heart Defect			Jaundice			Other: (please list)		
Cortisone Medicine			Kidney Disease			_____		
Cosmetic Surgery			Liver Disease			_____		
Cough			Mental Disorders			_____		
Diabetes			Nervous Disorders			_____		
Dizziness			Pain in Jaw Joint			_____		
Drug/Alcohol Addiction			Pregnancy			_____		
Emphysema/Asthma			Psychiatric Treatment					

Is your child allergic to or reacted adversely to any of the following?

	Y	N	What was the reaction?
Latex			_____
Aspirin			_____
Penicillin			_____
Erythromycin			_____
Tetracycline			_____
Codeine			_____
Sedatives or sleeping pills			_____
Dental anesthetic			_____
Any other medications:			_____
* If yes, what kind?			_____

AUTHORIZATION OF INFORMATION

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize, Dr. Fred Dahm, and/or dental staff to perform the necessary dental services that I may need.

Signature of Parent/Guardian

Date



ACKNOWLEDGMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree, than you are bound to abide by such restrictions.

PATIENT NAME: _____

Signature: _____

Date: _____

Dependent family members also covered by this Acknowledgement:



FINANCIAL POLICY

This statement is to inform you of our Financial Policy. We are committed to providing you with the highest quality of dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our Financial Policy is intended to facilitate excellent service to you while minimizing our administrative cost.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you, we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement at the bottom of this form. In order for our office to file your insurance claim, you must bring proof of insurance and notify us of any changes to your policy at each dental appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and American Express. Outside financing is available through Care Credit upon request and approval.

Returned checks and outstanding balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

If you have any questions regarding our Financial Policy, please ask. We are committed to providing you with the most positive experience in dental care.

PATIENT NAME: _____

Signature of Patient or Parent/Guardian if minor

Date



APPOINTMENT POLICY

Our office does require a two (2) business day notice to change or cancel an appointment. In our continued commitment to provide the highest quality of dental care available to all of our valued patients, a \$50.00 dollar fee will be applied if we do not receive the proper two (2) business day notice to reschedule or cancel an appointment.

PATIENT NAME: _____

Signature of Patient or Parent/Guardian if minor

Date