

Patient Information – Minor (18 and under)

Welcome!



Date: _____

Minor's Name:

First Last Middle Initial

Preferred Name: _____

Sex: Male ___ Female ___

Birthdate: ___/___/___ Age ___

School: _____ Grade: _____

Person responsible for account

Legal Name: _____ Relationship to Patient: _____

Address: _____

Telephone: (____) _____ (____) _____ (____) _____
Home# Work# Cell#

Can we text you appointment reminders Yes / No (circle one)

Birthdate: ___/___/___ Social Security #: _____

Email: _____

Can we email you appointment reminders? Yes / No (circle one)

Employer: _____ Occupation: _____

Employer Address: _____

If the responsible party above is NOT the person we should contact for appointment reminders, please provide contact person's info here:

Name & Relationship _____

Address & Phone Number _____

(OVER)



Insurance Information

PRIMARY DENTAL INSURANCE INFORMATION:	SECONDARY DENTAL INSURANCE INFORMATION:
Subscriber Name:	Subscriber Name:
Relationship to patient:	Relationship to patient:
Subscriber Social Security:	Subscriber Social Security:
Subscriber Date of Birth:	Subscriber Date of Birth:
Subscriber Employer	Subscriber Employer
DENTAL INSURANCE COMPANY:	DENTAL INSURANCE COMPANY:
Effective Date:	Effective Date:
Address of Dental Insurance Company:	Address of Dental Insurance Company:
Phone Number of Dental Insurance:	Phone Number of Dental Insurance:
Member ID #:	Member ID #:
Group #:	Group #:

Miscellaneous Information

Emergency Contact: _____ Phone #: _____
 Relationship to patient _____

Have any of your family members been to our office: Yes / No (circle one)

If yes, who? _____

How did you hear about us? (If internet, where? Google/Facebook/Yelp)? _____

OR Whom May We thank for the referral? _____

Authorization

I hereby authorize payment directly to Lang Dental Group of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Lang Dental Group to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals

Signature of Parent/Guardian

Date

(OVER)



Child Medical History (13 and under)



Name: _____ DOB ____ / ____ / ____

Health problems that your child has, or medications he/she may be taking, could have an important interrelationship with the dentistry he/she will receive. The following questions will insure that we provide him/her with accurate care during his/her visit.

Child's primary care doctor	Yes	No	If yes, doctor's name : _____
Has your child ever been hospitalized or had a major operation?	Yes	No	If yes, Please explain: _____
Has your child ever had a serious head or neck injury?	Yes	No	If yes, Please explain: _____
Is she/he on a special diet?	Yes	No	If yes, Please explain: _____
Do you consider your child a nervous patient?	Yes	No	If yes, Please explain: _____
Has your child ever had N2O or a sedative during treatment?	Yes	No	If yes, Please explain: _____
Is your child taking any medications, supplements, or drugs?	Yes	No	If yes, Please list: _____

Allergy to any of the following:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine
<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Sedatives
<input type="checkbox"/> Iodine	<input type="checkbox"/> Sulfa drugs
<input type="checkbox"/> Acrylic	<input type="checkbox"/> Metal
<input type="checkbox"/> Penicillin/ antibiotics	<input type="checkbox"/> Local Anesthetics
<input type="checkbox"/> Milk	<input type="checkbox"/> Latex
<input type="checkbox"/> Other _____	

Does your child have any of the following?

AIDS/HIV	Low Blood Pressure	Frequent Headaches
Anaphylaxis	Lung Disease	Heart Murmur
Anemia	Mitral Valve Prolapse	Heart Pacemaker
Anxiety	Pain in Jaw Joints	Heart Trouble/Disease
Artificial Heart Valve	Cold Sores	Hemophilia
Artificial Joint	Congenital Heart Disorders	Hepatitis A, B, or C
Asthma/Breathing Trouble	Convulsions	High Blood Pressure
Bleeding Issues	Diabetes: Type I or Type II	High Cholesterol
Bruise Easily	Epilepsy/Seizures	Hives/Rash
Cancer	Fainting Spells/Dizziness	Sickle Cell Disease
Chemotherapy	Psychiatric Care	Sinus Trouble
Hypoglycemia	Radiation Treatment	Spina Bifida
Irregular Heartbeat	Rheumatic Fever	Stomach/Acid Issues
Kidney Problems	Seasonal Allergies	Thyroid Disease
Leukemia	Scarlet Fever	Tonsillitis
Liver Disease	Frequent Diarrhea	Tuberculosis

If you have marked any of the illnesses above please explain/illness not listed: _____

Authorization

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent/Guardian

Date

(OVER)





Patient Name: _____ DOB ____ / ____ / ____

Consent: By signing this form, you do consent to our use and disclose of your personal health information to carry out treatment, payment activities, and other healthcare operations required by this office. You acknowledge you are aware of our need to share your protected personal health information and have received your patient rights notification explaining in detail our office privacy policy and information sharing policy.

Right to revoke: You have the right to revoke this consent at any time by giving us written notice. We will honor the request as of the day we receive your written notice. Please understand it will not affect any action taken before we received your revocation and we may decline to treat you or to continue treating you if you revoke this consent.

Changes to Privacy Practices: We reserve the right to change our privacy practices described in our Patients Rights Privacy Policy and Information Practices. If we change our practices we will issue a revised Patients Rights Privacy Policy and Information Practice Statement.

Patient Responsibility: We request timely notification of any changes to your personal information we maintain for you, such as but not limited to: health history information, address, telephone number, active insurance policy, or change in employer.

In addition to the above, please list who we may discuss your healthcare information with: (Please print name and relationship, more room on back if needed):

Name

Relationship to patient

Name

Relationship to patient

Authorization

I have read and understand the above information. I understand that by signing this form I am giving my consent for Lang Dental Group to use and disclose my protected health information to carry out treatment, payment activities and health care operations.

 X

Signature of Parent/Guardian *Date*

