CHILD HEALTH HISTORY

PARENT/GUARDIAN: The purpose of the following is to determine if your child has a medical condition that may require special care. All information is confidential and kept in your child's dental record. Please complete this form and remain in the dental office while your child is receiving treatment.

Name: _____ Birthdate____/____/____

Child prefers to be called: _____

Date of child's last medical examination: ____/____/____ Current Height: _____feet _____inches

Reason: _____ Current Weight: _____pounds

Medical History

Pediatrician Name: _____

Address _____

_____
City State Zip

Phone #: ( ) _____

Child's current physical health is: ❑ Good ❑ Fair ❑ Poor

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

Please explain: _____

_____

Does your child use tobacco in any other form? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Barbiturates	Y N Jewelry	Y N Seasonal
Y N Codeine	Y N Latex	Y N Sulfa Drugs
Y N Dental Anesthetics	Y N Other_____	

Please list additional drugs that cause allergic reactions: _____

_____

_____

For Women: Is child taking birth control pills? ❑ Yes ❑ No

Is child pregnant? ❑ Unsure ❑ Yes, week #:_____ ❑ No

Is child nursing? ❑ Yes ❑ No

Is child taking any prescriptions or over-the-counter drugs? ❑ Yes ❑ No

If yes, please list each one: _____

Please indicate if this child has ever been <u>diagnosed</u> or <u>treated</u> for any of the following:

Y N Abnormal Bleeding	Y N Emphysema	Y N Liver Disease
Y N Alcohol Abuse/Drug Abuse	Y N Epilepsy/Seizures	Y N Mitral Valve Prolapse
Y N Anemia	Y N Fainting Spells	Y N Pacemaker
Y N Arthritis	Y N Frequent/Severe Headaches	Y N Persistent Cough
Y N Artificial Bones/Joints	Y N Glaucoma	Y N Psychiatric Problems
Y N Artificial Heart Valves	Y N Hay Fever	Y N Radiation Treatment
Y N Autoimmune Disease	Y N Heart Attack	Y N Rheumatic Fever
Y N Asthma	Y N Heart Murmur	Y N Scarlet Fever
Y N Blood Transfusion	Y N Heart Surgery	Y N Sinus Problems
Y N Cancer	Y N Hepatitis Type _____	Y N Steroid Therapy
Y N Chemotherapy	Y N Herpes/Fever Blisters	Y N Stroke
Y N Colitis/Ulcers	Y N High/Low Blood Pressure	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N HIV+/AIDS	Y N Tuberculosis (TB)
Y N Diabetes	Y N Kidney Problems	Y N Venereal Disease
Y N Difficulty Breathing		

List any serious medical condition(s) that the child has experienced:

_____

Yes	No	
❑	❑	Was child born of a normal 9 month pregnancy? If premature, how many months?_____ Birth weight:_____lbs._____oz.
❑	❑	Is child physically or mentally handicapped in any way? If yes, how: _____
❑	❑	Does child need an update on immunizations? Has child ever received general anesthesia or sedation? ❑ Yes ❑ No
❑	❑	Is child in the grade appropriate for his/her age?

I have answered these questions for the patient (child) to the best of my knowledge and ability.

_____

Signature of parent or legal guardian Date

WELCOME

Thank you in advance for your coming to see us today. In order for us to better serve you, please take a few moments to complete this entire form. At Smile Linn Dental, we are committed to keeping your private healthcare information confidential.

Today's Date: _____

Person Financially Responsible for Account *(parent's name if minor)*:

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____

❑ Male ❑ Female Birthdate: ____/____/____ Age: _____

Social Security #: _____

Driver's License #: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone: (____)_____ Pager: (____) _____

Work Phone: (____)_____ Ext: _____

Cell Phone: (____) _____

E-mail: _____

Employer:

Employer's Name: _____

Employer's Address: _____

_____
City State Zip

Length of employment: _____

Occupation: _____

When are the best times to reach you? _____am _____pm

Whom may we thank for referring you? _____

_____

Second Person Responsible for Account/Spouse:

Name: _____ Birthdate: ____/____/____

Employer: _____

Driver's License #: _____

Work Phone: (____)_____ Home Phone: (____) _____

Relationship: _____

Social Security #: _____

Billing Address: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____ Birthdate: ____/____/____

Relationship to Patient: _____

Insured's SS #(required): _____

Insured Insurance ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group Number *(Plan, Local or Policy #)*: _____

Insured's Name: _____ Birthdate: ____/____/____

Relationship: _____

Insured's SS #: (required) _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

In the event of any emergency, whom should we contact?

Name: _____

Relation: _____

Work Phone: (____) _____

Home Phone: (____) _____

Cell Phone: (____) _____

Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number

Smile Linn Dental

PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION.

Authorization and Release

If you have dental insurance, we will prepare and submit your dental claims as a courtesy to you.

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

I acknowledge that I am financially responsible for all changes whether or not they are covered by insurance. I hereby authorize payment directly to West Linn Dental of the group insurance benefits otherwise payable to me. I also authorize release of any information including this diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including rebilling & interest charges, missed appointment fees, all collection costs and reasonable attorney fees. Any accounts sent for collections will be assessed an additional $100 processing fee.

We appreciate your keeping your scheduled appointments. We reserve time & expertise exclusively for you because you are important to us. If you should need to change or cancel your appointment, we kindly ask you give 48 hours notice. Appointments cancelled without 48 hours notice or failed appointments may be assessed a fee of $25 per half hour of scheduled time.

Payment plans and special arrangements must be made ***prior*** to treatment & approved by our office manager. Returned checks will be charged a flat rate of $25.00 per check per incident. Balances older than 60 days from the date of service, regardless of insurance, may be subject to the following interest charges. Interest is calculated at a rate of 1.5% per month (or 18% annually or a $5.00 rebilling fee (whichever is greater)) and applied monthly to unpaid account balances.

For your convenience, we accept most major credit cards. We also offer additional payment plans through an outside financing group. If you would like more information or have any questions, please let us know. We are happy to help.

Name *(Please print):*_____

Signature:_____ **Date:** _____

Patient:_____

FADI IBSIES, DMD
18750 SW WILLAMETTE DR., SUITE B-2 • WEST LINN, OR 97068
PHONE: 503.607.2222

Smile Linn Dental

HIPAA Acknowledgement & Consent

The staff at Smile Linn Dental is committed to maintaining the confidentiality of your personal, financial and health information. We are required by applicable federal and state laws to maintain the privacy of your personal health information. We are also required to give you this notice. This notice took effect in April 2003 and will remain in effect until we replace it.

By signing this form, you consent to our use and disclosure of your personal health information to carry out treatment, payment activities and other healthcare operations required by this office. You acknowledge that you are aware of our needs to share information and received your rights notification explaining in detail our office policy and information sharing policy.

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

We reserve the right to change our privacy policies described in our office patient right privacy policy and information practices. If we do change our practices, we will make available a revised patient and information privacy update statement.

We request that you provide notification to us of any changes in your personal information we maintain for you in a timely manner.

You may obtain a copy of Notice of Privacy Practices by contacting Dr. Ibsies at (503) 607-2222 or mailing us your request in writing to: Smile Linn Dental Attn: Dr. Ibsies 18750 Willamette Dr. Suite B2 West Linn, OR 97062

By signing this form, you confirm you have read the above information and have received a copy of this office's Notice of Privacy Practices. Your signature also gives consent to Dr. Fadi Ibsies & staff to use and disclose your protected health information to carry out treatment, payment activities and health care operations.

_____

Patient Name (Please Print)

_____ _____

Patient Signature (Parent or Guardian if Patient is a Minor) Date

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For Office Use Only

We attempted to obtain a written acknowledgement of Receipt of Notice of Privacy Policy and Information Practices, but it could not be obtained because:

_____ Individual refused to sign
_____ Communication barrier kept us from obtaining acknowledgement
_____ An emergency situation kept us from obtaining acknowledgement
_____ Other_____

Fadi Ibsies, DMD
18750 SW Willamette Dr., Suite B-2 West Linn, OR 97068 • (503) 607-2222 • www.smilelinndental.com