Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

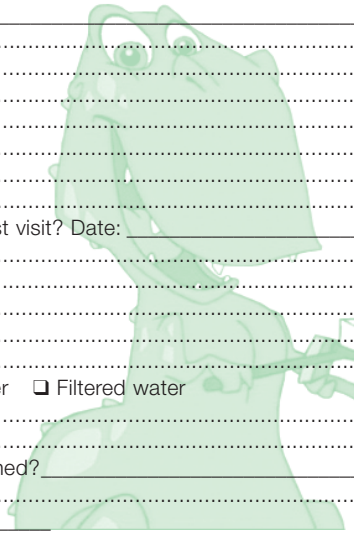
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Release of Prior Medical/Dental Records

I hereby authorize and give consent to Robert D. Perrott, DMD, Limited to obtain copies of my medical and dental records from current or past dentist, physicians and or hospitals. I hereby expressly authorize any dentist, physician, hospital or any other medical/dental care provider to release copies of my records to Dr. Perrott upon request.

I authorize any health care provider who has treated me to discuss my care and treatment with Dr. Perrott. This authorization shall be valid until withdrawn by me, in writing.

Print Patients Name: _____

Relationship to patient: _____

Signature: _____ Date: _____

Robert D. Perrott, DMD, Limited

Patient's Name: _____ Birthdate: _____

I give consent for myself/my child to receive dental treatment deemed necessary by the providers at the office of Robert D. Perrott, DMD, Limited. These procedures include, but are not limited to; examinations, oral prophylaxis (cleanings), fluoride treatments, sealants, restorations (composite fillings and crowns), periodontal (gum) treatments, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

_____	_____	_____
(print your name)	(relationship)	(date)
_____	_____	_____
(your signature)	(witness)	(date)

This section needs to be completed for children under the age of 18 by a parent or legal guardian ONLY.

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individuals named below to escort my child for dental treatments:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If child is over 13, please check one:

☐ Since my child is over the age of 13, I also give permission for him/her to present for treatments unaccompanied by an adult. I understand that no invasive treatment, such as extractions or the initiation of root canal therapies, will be performed unless I am notified by telephone. In the event of an emergency, when I cannot be reached, I give permission to perform whatever therapies are deemed necessary by the treating provider.

☐ Although my child is over 13, I wish to be present for all treatment performed.

_____

Signature of parent or legal guardian

This consent shall be considered in effect until rescinded or revoked in writing.

Robert D. Perrott. DMD

In order for us to stay within the HIPAA guidelines, please list below anyone that you authorize us to disclose information to regarding your Protected Health Information. It is not mandatory that you list anyone. **(You do not need to list any of your doctors).**

Name	Relationship
1._____	_____
2._____	_____

Do we have your permission to leave information on your **answering machine** or **voicemail** if we are unable to reach you? ____ Yes ____ No

Do we have your permission to send you a **text message** in regards to an appointment? ____ Yes ____ No

What is the best number to contact you at: _____.

Do we have your permission to send you an **email** in regards to an appointment? ____ Yes ____ No

What is the best email address? _____.

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient or Parent/Guardian Signature Today's Date

HIPAA PRIVACY FORM 2

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign this Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.
(Please Print Patient Name)

_____ _____
Patient or Parent/Guardian Signature Today's Date

7200 Bristlewood Drive Boardman, Ohio 44512

Financial Responsibility Form

Purpose:

The purpose of this document is to make sure that our patients understand the financial aspect of our relationship. First of all, thank you for giving our office the opportunity to care for your dental needs! We truly value the relationship we have with you and your family and strive to do our very best to provide the highest quality care available with a conservative and compassionate approach. We understand that quality dental care can be costly at times so we are pleased to offer various payment options.

Dental Insurance:

Those who have dental insurance are very fortunate to have some of the cost associated with dental care paid by the plan. Please keep in mind insurance is a benefit-it is not designed to pay for all of your care and the coverage provisions of an insurance plan should not be confused with what dentistry is needed or appropriate in your particular circumstance-only Dr. Perrott and you can determine that. As a convenience to you our office will be happy to submit claims to your insurance company. Our computer software estimates what your insurance may cover and estimate your "out of pocket" patient portion. THIS IS ONLY AN ESTIMATE. Our office makes no guarantees or promises that your insurance will cover any or all of your treatment. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claims. We encourage you to be active in the timely payment of your dental claims, if your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and subject to finance charges and additional collection cost incurred from outside party to collect on your unpaid debt.

Payment Options:

- **For patients with insurance**, your estimated portion is due at time of service. Please understand we DO NOT "bill for services."
- **For patients without insurance**, payment is due at the time of service, we accept Visa, Discover, MasterCard, or CareCredit. Those who pay with cash or check will receive a 5% discount, for those 65 years old and older we offer a 5% Senior discount. Please understand we DO NOT "bill for services." Discounts applied when payment is made at time of service.
- **Interest Free Payment**, is offered though CareCredit®. This company is not affiliated with Dr. Robert Perrott and we do not have control over acceptance in the program. We will assist you in the application process as much as we possibly can. The end result would be an agreement between you and CareCredit®.

Delinquency / Returned Checks:

If your account is 60 days past due, you will receive a letter stating that you have 15 days to pay your account in full. Please be aware that if a balance remains unpaid your account will be referred to an outside collection agency or attorney, YOU will be responsible for the collection costs, along with reasonable attorney fees and court costs incurred by our office. Payment will be required on past due balances before you will be seen for non-emergency appointments. Returned checks will be subject to additional fees and loss of check writing privileges in this office.

Minor Patients:

It is the policy of the office that whomever brings the child in for their dental appointment will be responsible for payment for services rendered that day.

Patient initials: _____

Turn over to backside

Late Cancellations or Missed Appointments:

Please understand that our appointment times are scheduled to allow us to take care of each individual's needs during the patient's visits. Since appointment times at our office are in high demand, we value advanced notice from our patients who are unable to keep their scheduled appointments. In an effort to decrease unnecessary costs related to staffing and supplies, we maintain a No-Show/ Cancellation policy for all of our patients. **We require that you give our office at least a 48-business hour notice** if you need to reschedule your appointment. In the event an appointment is missed or cancelled without contacting our office within the required time, a fee will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without the payment of this fee. If three no-show or same day cancellations occur, in a 12-month period, we reserve the right to terminate the doctor-patient relationship. This policy is in effect for all appointments at our office. Please acknowledge that you have had the opportunity to review this policy by signing below.

I, the undersigned, hereby authorize the release of any information relating to all insurance claims for benefit submitted on behalf of myself, spouse, or dependents including the assignment of benefits payable to Robert D. Perrott DMD, Limited.

I also understand it my responsibility to notify the office with updated insurance information, address and phone numbers as we are not notified of such changes other than by you, the patient.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. Significant cost incurred in carrying our patients accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all terms and conditions herein.

_____

Print Patient Name

_____

Signature of patient or responsible party Today's Date