Child Health History and Information

Child's Name _____ Male ____ Female____ Today's Date _____

Child's Birth Date____/____/____ Child's Nickname _____ Hobbies_____

HomeAddress_____City_____State_____Zip_____

Home Phone #_____Child's School _____ Grade_____

Parent Information

Mother's Name_____ SS#_____ Birth Date ____/____/____

Employer_____ Employer's Phone #_____

Home Phone #_____ Cell Phone #:_____ Email _____

Father's Name _____ SS#:_____ Birth Date ____/____/____

Employer_____ Employer's Phone #_____

Home Phone #_____ Cell Phone #:_____ Email _____

Person Financially Responsible (if other than parent) _____Relationship to Child_____

Medical History

What is your child's current weight?_____lbs.

Reason for today's visit?_____

How did you hear about our office? _____

Has your child ever had serious/difficult problems with dental care? Yes_____ No_____

Has your child ever had any pain in their jaw joint (TMJ/TMD)? Yes_____ No_____

Does your child brush their teeth daily? Yes___ No____ Floss their teeth daily? Yes___ No____

Has your child had any condition or treatment related to the following? If so, please circle:

HEART LIVER DIABETES HEADACHES CANCER BLEEDING KIDNEYS LUNGS SKIN
PSYCHIATRY BRAIN/ NERVOUS SYSTEM IMMUNE SYSTEM (HIV or AIDS) STOMACH / GI BLADDER
ALLERGIES ADHD BEHAVIOR DISORDER AUTISM SPECTRUM SPEECH/LANGUAGE OTHER

If any circled, **please describe:**

_____

Please list any known allergies: _____

Please list all medications your child is currently taking: _____

Do any of the following apply to your child? If so, please circle:

THUMB/FINGER SUCKING NAIL BITING NURSING BOTTLE HABBITS LIPS SUCKING/BITING

WELL WATER I FLOSS MY CHILD's TEETH DIFFICULTY IN NEW SITUATIONS OUTGOING

Choose One:

☐ I desire complete diagnostic and preventive care for my child (whether I am with them or if they are in the office with a sibling, grandparent or other caregiver). This would include x-rays, cleanings, sealants or fluoride. If there is a possibility that my child (under 18) comes to the office without me, I will complete a "Consent to Treat Form" that is available on the practice website: www.CornerstoneDentalHealth.com

☐ I do not want any diagnostic or preventive service performed other than what was scheduled by me. I understand that by checking this box I may need to schedule another appointment to have these services completed

Child's Physician_____ Location _____Phone #:_____

Pharmacy_____ City_____

Previous Dentist _____ Date of Last Dental Visit_____

Preferred Payment Method and Account Information:

Private Pay_____ Other (such as Power of Attorney) _____

Insurance: _____ - *please fill in the following box-* Is there Secondary Insurance? _____

Dental Ins. Group/Plan #_____ ID #_____Name of Guarantor_____Phone_____

Address_____ City_____ State_____Zip_____ Soc. Security #_____-____-_____

Names of Insured under Primary Plan:_____

What would you say is/are the primary reasons you selected our office for care? *circle up to 3*

My friend/ family recommended Pleasant office staff High Tech Relaxing Treatment Laughing Gas

Computer Controlled Anesthesia Pleasant office staff Doctors extra education/ awards Doctors great with kids

Payment Policies

Payment is expected when services are rendered unless other arrangements are made in advance.
Payment may be made with cash, personal check, MasterCard, VISA, Discover or American Express.

Two arrangements are available for deferred payment (with approval):

1-Simple billing: A statement will be sent, usually around the 25th of the month. It is due in full by the *next* billing cycle. Any unpaid balance will be subject to a billing charge of **$5 per statement**, or a finance charge of 1.39% per month, (18% expressed as an Annual Percentage Rate [APR]), whichever is greater.

2-For complex treatment plans: Payment may be made over 3 months with no interest or billing charge. After 3 billing cycles the balance will be *due in full and subject to finance charges* as explained above.

Insurance: In cases where we have accepted assignment of benefits, you will be billed for your estimated portion. You will have 30 days to pay, after which finance charges will begin as explained above.

Costs of Collection: If we refer the collection of your account to an attorney, you agree to pay our reasonable attorney's fees, court costs or other collection costs as permitted by law.

Everyone at Cornerstone Dental Health strives to improve patient care through continuing education and case studies of treatment. Before and after photos are sometimes required during treatment to properly document conditions. Additionally, doctors Moon and Obrock often teach at educational meetings and would appreciate your permission to use these photos. Patients are never identified, and your privacy is protected as personal health information and is never shared under any circumstances. If you object to the use of any photos for teaching purposes initial here ____ .

I have read and understand the terms and policies set forth in "Payment Policies" as outlined above, and agree to abide by them. I have read and answered all health history questions to the best of my knowledge. I understand it is my responsibility to inform on any changes/additions to this history at the time of such changes and prior to planned treatment is completed.

Signature: _____ **Date**:_____