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:

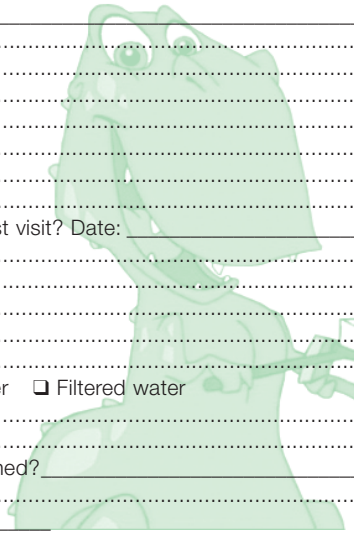
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic 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

Christopher K Yang D.M.D.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

To summarize this form, you are giving consent for our clinic to use your information to help our office coordinate with insurance companies, other doctors who are treating you, persons responsible for your account, and/or as required by law.

This form also refers to the Notice of Privacy Practices, which lets you know how our office protects your health information and allows disclosure of your health information only with your permission and/or as required by law. Please ask our office if you have any questions.

SECTION A: Patient Information

Name: _____ DOB: _____

Additional information if not already on file:

Address: _____

Telephone: _____ Email: _____

SECTION B: To the Patient – Please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent and is available at the front desk. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, the revised Notice of Privacy Practices will be available at the office front desk. You may also obtain a copy at any time by contacting:

Contact Person: Christopher Yang
Telephone: 920-457-2410
E-mail: *dental@yangdmd.com*
Address: 1214 S 23rd St, Sheboygan, WI 53081

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship: _____

Office Use Only

Patient declined to sign the Consent for Use and Disclosure of Health Information form. Staff Initials and Date: _____

--HIPAA Consent on Next Page--

Christopher Yang Dental – Patient Financial Agreement

Oral health is the foundation of our relationship and we strive to provide outstanding care for our patients. We offer the following agreement and payment options.

For our patients with dental insurance:

We will gladly verify your dental benefits and process your primary and secondary insurance claims with the following agreement:

- Your dental insurance is an agreement between you and your insurance company.
- All patient copayments and/or patient portions are only an estimate. They are not a guarantee of payment.
- As part of your contract with your insurance company, you are responsible for all out of pocket portions/copayments and deductibles.
- Insurance payments not paid after 45 days of billing will become your complete responsibility and must be paid in full.

For our patients without dental insurance:

Payment in full is due at the time of service, unless arrangements have been made prior to your scheduled appointment. Financing is available upon request. Please ask our office if you would like more information.

Our office honors fees for 6 months after a treatment plan is given. If any treatment has not been completed within 6 months, our fees are subject to change to the most recent fee schedule.

Statements/Finance Charges:

All patients with an outstanding balance will receive monthly statements. Balances older than 60 days are subject to collection fees and interest charges of ***1.5% per month***. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance.

Payment Options:

For your convenience, we accept cash, check, Visa, MasterCard, Discover, American Express, HSA/FSA, and CareCredit. There is a $35 fee for any checks returned due to insufficient funds.

CareCredit is available to help with patients finance larger dental or orthodontic cases. No down payment is required and payments can be made up to 6 months with no interest.

Missed appointments or short notice cancellations:

We understand that illness or other problems can occur (sometimes without any warning), we will not charge you for your first missed or cancelled appointment. In the event a second appointment is missed or cancelled with less than 24 hours notice or no notice, a fee of $35 charge may be billed to your account. Please help us service you better by keeping scheduled appointments.

I understand my financial options and that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office regardless of insurance benefits. In the event my account becomes delinquent, I will be responsible for any collections, legal fees, and any other charges incurred to collect this account. I authorize Dr. Christopher Yang DMD and/or any provider of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand the financial agreement terms and policies and agree to follow them.

Signature of patient or responsible party: _____ Date: _____

Relationship to patient: _____
