Patient Information

*Date:*_____

*Pt's Name*_____ *Birthdate*_____ *Sex*_____
*Address*_____ *City*_____ *State*_____ *Zip*_____
*Phone*_____ *(cell)*_____ *Pt's S.S.N.*_____

*Father's Name*_____ *Birthdate*_____ *S.S.N.*_____
*Address*_____ *City*_____ *State*_____ *Zip*_____
*Phone (home)*_____ *(work)*_____ *(cell)*_____

*Mother's Name*_____ *Birthdate*_____ *S.S.N.*_____
*Address*_____ *City*_____ *State*_____ *Zip*_____
*Phone (home)*_____ *(work)*_____ *(cell)*_____

Method of Payment

*Responsible Party*_____ *Relationship*_____
*S.S.N.*_____ *Phone (home)* _____ *(work)* _____
*Address*_____ *City*_____ *State*_____ *Zip*_____
*Employer & Address*_____
_____

Medicaid: *Number* _____

****PRIMARY****

*Insured Person:*_____ *SSN*_____ *Birthdate*_____
Dental Insurance Co: _____ *Policy*_____
*Address:*_____ *City*_____ *State*_____ *Zip*_____
*Employer & Address*_____

****SECONDARY****

*Insured Person:*_____ *SSN*_____ *Birthdate*_____
*Dental Insurance Co:*_____ *Policy*_____
*Address:*_____ *City*_____ *State*_____ *Zip*_____
*Employer & Address*_____

CONSENT FOR TREATMENT AND AGREEMENT

Dr. Litz strives to provide excellent dental care at a reasonable cost to your children. Her schedule is very busy, but she will always spend as much time with you and your child as necessary so that the procedures are performed correctly, and so that you understand exactly what she is doing. **IF YOU HAVE ANY QUESTIONS ABOUT THE INFORMATION ON THIS PAPER, DO NOT SIGN IT UNTIL YOU HAVE SPOKEN TO THE DENTIST OR A STAFF MEMBER.**

By signing below, you agree:

1. **That Dr. Litz may treat you or your child.** You agree that Dr. Litz and/or her staff may perform an evaluation on you or your child, after which a treatment plan will be provide you a copy. You also agree that Dr. Litz may provide treatment to you or your child pursuant to that treatment plan, and that a subsequent consent need not be signed.
2. **To keep your appointments and to arrive at the scheduled time.** If you are unable to keep your appointment, you agree to notify at least 24 hours in advance. If you do not notify her in advance, or if you fail your appointment, you agree that Dr. Litz may charge you account a "missed appointment" fee.
3. **To pay your bill promptly.** Dr. Litz has spent many years studying to be able to specialize in children's dentistry. She is performing a valuable service at your request, and deserves to be paid in a timely manner. You agree, therefore that you will pay your portion of the bill at the time of service, and any remaining balance after insurance has paid its portion of the bill, and you assign your right to insurance payments to Dr. Litz. You agree that even if you have insurance, you are responsible for the paying the bill. If your insurance has not paid for the charges within sixty (60) days of service, you agree to pay the balance on the charges. If you do not pay the bill, or make satisfactory arrangements, you agree that Dr Litz may refer to the matter to an attorney for collection, and that in such event, you will pay a $50 collection cost, attorney's fees, and court costs. **You further agree that jurisdiction for any lawsuit filed to recover fees shall be in Morgan County, Indiana,** and you consent to the courts in Morgan County having jurisdiction over this matter.
4. **To inform us if your or your child's information changes.** You agree that even if someone else later brings your child to see Dr. Litz, you are still financially responsible for the bill. If you wish someone else to pay the bill, that person will have to sign this agreement. You also agree that unless you notify us in writing of a different address, the one you supply us with is where we will sent statements.

ACKNOWLEDGEMENT OF NOTICE

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

Notice of Privacy: You have the right to read our Notice of Privacy Practices. We encourage you to read it carefully and completely before signing this Consent.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice. Revocation of this Consent will not affect any action we took prior to the revocation, and that we may decline to continue treatment if you revoke this Consent.

*I have had full opportunity to read and consider this Consent form and the Notice of Privacy Practices. I understand the contents of this form and am giving consent for use and disclosure of my information, to carry out treatment, and payment activities.

_____ _____ _____

(Parent, or person responsible for payment) (Relationship to patient) (Date)

SS# _____ Date Of Birth _____

Please list anyone else that we may discuss patient scheduling, treatment and financial arrangements with:

_____ _____ Phone _____

_____ _____ Phone _____

(Name & Relationship)

MEDICAL-DENTAL HISTORY

Child's Name _____ Sex _____ DOB_____ Date _____

Child's Doctor _____ Date of last exam _____
Doctor Address_____ Doctor's Ph # _____

Growth/Development:?

Any learning, behavorial, or communication problems?	No ( ) Yes (
Has had counseling or will be in the future?	No ( ) Yes (
Any complications with pregnancy or child birth (premature)?	No ( ) Yes (
Any growth problems?	No ( ) Yes (
Central Nervous System:	
Any history of cerebral palsy, seizures, loss of consciousness or fainting?	No ( ) Yes (
Any injuries to the head?	No ( ) Yes (
Any sensory disorders? (seeing, hearing)?	No ( ) Yes (
Cardiovascular System:	
Any history of congenital heart disease, heart murmur, or rheumatic fever?	No ( ) Yes (
Has any heart surgery been done or recommended?	No ( ) Yes (
Any history of chest pains or high blood pressure?	No ( ) Yes (
Blood or Lymphatic Systems:	
Has your child ever had a blood transfusion or blood products?	No ( ) Yes (
Any history of anemia or sickle cell disease?	No ( ) Yes (
Bruise easily, frequent nosebleeds, or bleeds easily from cuts?	No ( ) Yes (
Is your child susceptible to infections?	No ( ) Yes (
Any history of tender or swollen lymph nodes?	No ( ) Yes (
Respiratory System:	
Any history of pneumonia, asthma, cystic fibrosis, or lung diseases?	No ( ) Yes (
Gastrointestinal System:	
Any history of stomach, intestinal, or liver problems?	No ( ) Yes (
Any history of hepatitis or jaundice?	No ( ) Yes (
Any history of eating disorders or unintentional weight loss?	No ( ) Yes (
Genitourinary System:	
Any history of urinary tract infections, bladder, or kidney problems?	No ( ) Yes (
Any history of pregnancy or pregnant now?	No ( ) Yes (
Endocrine System:	
Any history of diabetes, thyroid disorders, or glandular problems?	No ( ) Yes (
Skin:	
Any history of skin problems, cold sores, or canker sores?	No ( ) Yes (
Extremities:	
Any arthritis (joint) problems?	No ( ) Yes (
Any limitations of use of arms or legs- muscle weakness/dystrophy?	No ( ) Yes (
Allergies:	
Any allergies to medicines?	No ( ) Yes (
Any hives, skin rashes, hypersensitivities (latex), or other allergies?	No ( ) Yes (

MEDICAL-DENTAL HISTORY

Medications or Treatments: (please list)	Dosage	Time/Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Ever received radiation/chemotherapy or diagnosed with cancer? No ( ) Yes (

Hospitalizations:

Hospital	(1) _____	(2) _____	(3) _____
Date	_____	_____	_____
Reason	_____	_____	_____

Immunizations:

DPT No ( ) Yes ( ) Polio No ( ) Yes ( ) MMR No ( ) Yes ( )
Hib No ( ) Yes ( ) Hepatitis B No ( ) Yes ( )

	Now	Exposed	Past
AIDS	_____	_____	_____
Chicken Pox	_____	_____	_____
Earache	_____	_____	_____
Eye Infection	_____	_____	_____

DENTAL HISTORY

Does your child have a toothache or other problem? No ( ) Yes (
Ever have a injury to the mouth, teeth, or jaw? No ( ) Yes (
Is this their first visit to the dentist? No ( ) Yes (
If no: Date_____ Dentist_____
Ever have an unfavorable dental experience? No ( ) Yes (
Is (was) your child nursed beyond 1 years old? No ( ) Yes (
Eat a well balanced diet? No ( ) Yes (
My child drinks (please check) Milk ____, Pop ____, Koolaide (Hi-C)_____, Juices _____
Habits: Thumb ____ Finger ____ Pacifier ____ Nail biting ___ Teeth grinding ____
Any difficulties with the jaws? Opening ____ Clicking ____ Pain ____

PREVENTION

How often are teeth: Brushed/day _____ Flossed _____
Is child assisted with brushing? No ( ) Yes (
Are teeth inspected after the child brushes? No ( ) Yes (
Water: City _____ Well_____ Fluoride Content _____
Type of toothpaste used: _____

Signature _____