PEDIATRIC DENTAL CLINIC
DAVID H. MERRITT, D.M.D., M.S., P.C.
PEDIATRIC DENTISTRY
162 ANA DRIVE
FLORENCE, ALABAMA 35630
TELEPHONE (256) 766-0270

I. General Information:

Date _____

Father _____ Date of Birth _____ Social Security #_____

Home Address _____

City, State, Zip Code _____

Home Phone Number_____Work Phone Number_____Cell_____

Employed by _____

Address _____ City _____ State _____ Zip _____

Do you have Dental Insurance? Yes ____ or No ____

If yes, Name of Company _____

Group Number_____ Policy Number_____

Family Dentist _____

Email Address _____

Mother _____ Date of Birth _____ Social Security #_____

Home Address _____

City, State, Zip Code _____

Home Phone Number_____Work Phone Number_____Cell_____

Employed by _____

Address _____ City _____ State _____ Zip _____

Do you have Dental Insurance? Yes ____ or No ____

If yes, Name of Company _____

Group Number_____ Policy Number_____

Family Dentist _____

Email Address _____

II CHILD'S HISTORY:

Child's Name _____ Nickname _____

Age _____ Date of Birth _____ Place of Birth _____

Male _____ Female _____ Social Security Number _____

Attends What School _____

Names and ages of brothers and sisters _____

Child's Physician or Pediatrician _____ Phone Number _____

Whom may we thank for referring you? _____

Nearest relative not living in the same household _____

Address _____ Phone _____

CHILD'S HEALTH HISTORY

Has your child experienced any of the following ?

	YES	NO		YES	NO		YES	NO
Heart disease	___	___	Liver Problems	___	___	Seizure disorder	___	___
Heart murmur	___	___	Hepatitis	___	___	Speech disorder	___	___
Rheumatic fever	___	___	Kidney problems	___	___	Hearing problem	___	___
Bleeding problems	___	___	Muscle problems	___	___	Vision problems	___	___
Anemia	___	___	Premature birth	___	___	Cerebral palsy	___	___
Blood transfusions	___	___	Diabetes	___	___	Headaches	___	___
Asthma	___	___	Mental disorder	___	___	Mental retardation	___	___
Allergies	___	___	Nervous disorder	___	___	HIV positive	___	___
Bronchitis	___	___	Fainting	___	___	AIDS	___	___
						Autism	___	___

Other health problems _____

Has any immediate family member had any of the above? Please describe _____

Is your child taking any **medications**? List if any _____

Has your child ever been **hospitalized**? Give reason (s) and hospital(s) _____

Has your child had any **surgery** ? (Include tonsils and adenoids, ear tubes etc.) _____

Has your child had any unfavorable reaction or **allergy** to any medication such as penicillin or novocaine ?_____

When did your child last have a **physical exam**? Date and physician_____

CHILD'S DENTAL HISTORY

Is this your child's first visit to the dentist ? YES __ NO __ If no, give date & service performed_____
What is your main concern about your child's dental health ? _____
Has your child ever complained about a dental problem, or had any unhappy dental experiences ? Please explain.
_____
Is your child presently having a dental problem ? Please describe _____
Has your child had any injuries to the mouth or face area ? Please describe _____
Was your child breast fed? YES ____ NO ____ Was your child bottle fed ? YES ____ NO ____
Age when your child began drinking from a cup._____
Does your child have any of the following habits ?

	YES	NO		YES	NO
Thumbsucking of fingersucking	___	____	Nail biting	____	____
Mouth breathing	___	____	Pacifier sucking	____	____

Has your child ever worn orthodontic appliances ? YES ____ NO _____
What is the source of your drinking water? City / County system ____ Well or spring _____ Other _____
Has your child ever been given any fluoride ? (such as vitamins, drops or tablets) YES ____ NO ____
How often are your child's teeth brushed ? _____ flossed ? _____
Is your child assisted in brushing and flossing ? YES ____ NO _____
Do you consider your child to be (check one) ____ advanced in learning ___ progressing normally ___ slow learner
How do you expect your child to behave in our office ? _____
_____
Thank you for your help . If there is any information that you feel might be of value to us in the treatment of your child, please add it here: _____

_____ _____
Parent or guardian Date

Pediatric dentist date

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PAYMENT POLICY

PATIENT NAME(S): _____

PERSON RESPONSIBLE FOR PAYMENT: _____

S.S.#: _____ RELATION TO PATIENT: _____

ADDRESS: _____

Telephone: Home _____ Office _____ Cell _____

- FOR OUR PATIENTS **WITHOUT** DENTAL INSURANCE:
  - PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
  - VISA AND MASTERCARD ARE ACCEPTED.
- FOR OUR PATIENTS **WITH** DENTAL INSURANCE:
  - CO-PAYMENT IS DUE WHEN SERVICES ARE RENDERED.
  - WE WILL FILE AN INITIAL CLAIM FOR THE DENTAL PROCEDURE.
  - THE AMOUNT OF PAYMENT WILL BE HELD CURRENT FOR 60 DAYS IF AFTER 60 DAYS THE CLAIM HAS NOT BEEN PAID BY THE INSURANCE COMPANY, YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL.

I HAVE READ THE ABOVE PAYMENT POLICY FOR THE PEDIATRIC DENTAL CLINIC AND AGREE TO SUBSCRIBE TO THE APPROPRIATE PAYMENT POLICY PROCEDURE.

Signature of Responsible Party: _____

Date: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my child's protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my child's protected health information to carry out:

* Treatment (including direct or indirect treatment by other healtheare providers involved in my child's treatment);
* Obtaining payment from third party payers (e.g. my insurance company);
* The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my child's protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my child's protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

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