WELCOME!

Jon E. Cabot, D.D.S., M.S., P.C.
Megan E. Stowers, D.D.S., M.S.
Specialists in Dentistry for Children

YOUR CHILD

NAME ______________________ TODAY'S DATE ____/____/____

PREFERS TO BE CALLED ______________________ BIRTH DATE ____/____/____

ADDRESS ______________________

CITY ____________ STATE ________ ZIP ________ PHONE ____________

NAME OF SCHOOL ______________________ CITY ____________ STATE ________

OTHER THAN PARENT,
WHOM SHALL WE CONTACT IN CASE OF EMERGENCY ______________________

RELATIONSHIP TO CHILD ______________________ PHONE ____________

OTHER CHILDREN & THEIR AGE(S) ______________________

WHOM MAY WE THANK FOR REFERRING YOU ______________________

PARENT INFORMATION

❑ MOTHER ❑ FATHER ❑ STEPMOTHER ❑ STEPFATHER ❑ GUARDIAN

NAME ______________________ BIRTH DATE ____/____/____

ADDRESS ______________________

CITY ______________________ STATE ________ ZIP ________

HOME PHONE ______________________ CELL ______________________

DRIVER'S LICENSE# ______________________ SS# ______________________

EMPLOYER ______________________ OCCUPATION ______________________

WORK PHONE ____________ ADDRESS ______________________

CITY ______________________ STATE ________ ZIP ________

MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

PARENT INFORMATION

❑ MOTHER ❑ FATHER ❑ STEPMOTHER ❑ STEPFATHER ❑ GUARDIAN

NAME ______________________ BIRTH DATE ____/____/____

ADDRESS ______________________

CITY ______________________ STATE ________ ZIP ________

HOME PHONE ______________________ CELL ______________________

DRIVER'S LICENSE# ______________________ SS# ______________________

EMPLOYER ______________________ OCCUPATION ______________________

WORK PHONE ____________ ADDRESS ______________________

CITY ______________________ STATE ________ ZIP ________

MARITAL STATUS ❑ SINGLE ❑ MARRIED ❑ SEPARATED ❑ DIVORCED ❑ WIDOWED

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE OTHER SIDE.

DENTAL INSURANCE INFORMATION

DATE________________

NAME OF INSURED ____

RELATIONSHIP TO PATIENT ______________________________ BIRTH DATE _____/_____/_____

SS# ______________________ DRIVER'S LICENSE# ______________________

NAME OF EMPLOYER ______________________ PAYOR ID# ______________________

OCCUPATION ______________________ WORK PHONE ______________________

ADDRESS OF EMPLOYER ____

CITY ______________________ STATE ____________ ZIP ____________

DENTAL INSURANCE COMPANY ____

GROUP# ______________________ POLICY/ID# ______________________

INSURANCE COMPANY PHONE# ____

INSURANCE COMPANY ADDRESS ____

CITY ______________________ STATE ____________ ZIP ____________

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? ❑ **YES** ❑ **NO** ***IF YES, COMPLETE THE FOLLOWING:***

DATE________________

NAME OF INSURED ____

RELATIONSHIP TO PATIENT ______________________________ BIRTH DATE _____/_____/_____

SS# ______________________ DRIVER'S LICENSE# ______________________

NAME OF EMPLOYER ______________________ PAYOR ID# ______________________

OCCUPATION ______________________ WORK PHONE ______________________

ADDRESS OF EMPLOYER ____

CITY ______________________ STATE ____________ ZIP ____________

DENTAL INSURANCE COMPANY ____

GROUP# ______________________ POLICY/ID# ______________________

INSURANCE COMPANY PHONE# ____

INSURANCE COMPANY ADDRESS ____

CITY ______________________ STATE ____________ ZIP ____________

HEALTH HISTORY

IT IS IMPORTANT WE KNOW YOUR CHILD'S HEALTH! PLEASE ANSWER ALL QUESTIONS!

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CHILD'S NAME ______ GENDER: M ____ F ____ DATE OF BIRTH ______

CHILD'S PRIMARY CARE PHYSICIAN ______ PHONE ______ CITY ______

DATE AND REASON FOR LAST MEDICAL VISIT ______

MEDICAL

IF YOU RESPOND YES TO THE QUESTIONS BELOW PLEASE EXPLAIN ON THE PROVIDED LINES.

IS YOUR CHILD UNDER TREATMENT BY A PHYSICIAN? YES ❑ NO ❑

______

IS YOUR CHILD TAKING ANY MEDICATIONS (PRESCRIPTION, OVER-THE COUNTER)? YES ❑ NO ❑

MEDICATIONS (DOSAGE) ______

HAS YOUR CHILD EVER BEEN SERIOUSLY SICK, HOSPITALIZED OR HAD SURGERY? YES ❑ NO ❑

______

DOES YOUR CHILD HAVE ANY PHYSICAL, MENTAL OR EMOTIONAL DISABILITIES? YES ❑ NO ❑

______

IS YOUR CHILD ALLERGIC TO ANY MEDICATION OR PRODUCTS? YES ❑ NO ❑
(SUCH AS PENICILLIN, ARTIFICIAL FLAVORS/COLORS, LATEX)

______

IS YOUR CHILD PREGNANT? YES ❑ NO ❑

______

HAS YOUR CHILD HAD OR HAVE A HISTORY OF THE FOLLOWING? PLEASE CIRCLE ALL THAT APPLY.

ASTHMA	HEPATITIS	HEART DISORDERS	TUBERCULOSIS
ANEMIA	INFECTIOUS DISEASES	SICKLE CELL DISEASE	RECURRENT EAR INFECTIONS
BLEEDING DISORDERS	KIDNEY OR LIVER DISORDER	CANCER	AIDS/HIV
DIABETES	CHILDHOOD DISEASE (MUMPS, MEASLES)	SEIZURES	CEREBRAL PALSY
		DOWN SYNDROME	EPILEPSY

DENTAL

IF YOU RESPOND YES TO THE QUESTIONS BELOW PLEASE EXPLAIN ON THE PROVIDED LINES.

IS YOUR CHILD EXPERIENCING PAIN/DISCOMFORT/SWELLING OR TOOTHACHES? YES ❑ NO ❑

______

HAS YOUR CHILD EXPERIENCED ANY SIGNIFICANT TRAUMA TO THE FACE OR JAW? YES ❑ NO ❑

______

DO YOU HAVE ANY CONCERNS REGARDING YOUR CHILD'S ORAL HEALTH? YES ❑ NO ❑
(HYGIENE, GROWTH AND DEVELOPMENT, HABITS)

______

AUTHORIZATION AND CONSENT FOR TREATMENT FORM

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORM HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN PUT MY CHILD'S HEALTH AT RISK AND THAT IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL/DENTAL STATUS.

I UNDERSTAND THAT I WILL BE INFORMED OF THE RECOMMENDED TREATMENT FOR MY CHILD BEFORE ANY SERVICES ARE RENDERED AND MY SIGNATURE AUTHORIZES PROCEDURES DEEMED NECESSARY BY THE DOCTORS AND STAFF. I AGREE AND UNDERSTAND (REGARDLESS OF MY INSURANCE STATUS), THAT THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT IN FULL.

Parent/Guardian Signature ______ Date ______

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Welcome to our Office! To avoid any misunderstandings, we would like to inform you of some our policies. Please read the information carefully and sign below.

FINANCIAL POLICIES

Ultimately, you are responsible for your account. As a courtesy patients, we will file your insurance claim. An insurance policy is a contract between insurance carrier and employer. They determine the benefits you receive. We will estimate your co-pay and ask you to pay the co-pay at the time of service. If there is any amount your insurance does not cover, or if the claim is denied, you will be responsible for that amount. We urge you to be fully informed of the insurance benefits available to you through your employer.

Payment is due at the time services are rendered. For your convenience, we accept cash, checks and credit cards. There will be a $10.00 monthly rebill fee on any unpaid balances after the first statement. If your account becomes delinquent beyond 30 days, you may be responsible for all costs incurred to collect on the account including collection agency fees, court costs, and attorney's fees as well as interest accured. Please let us know if there are extenuating circumstances and we will be happy to make special payment arrangements. We realize that many families are in a state of change. Divorce, separated, single parent and blended families are now common. The policy in our office is the parent who requests treatment for the child is responsible for all fees incurred.

APPOINTMENT POLICIES

If it is necessary for you to reschedule or cancel your appointment, we request at least 24-hour notice. This allows us the opportunity to offer this time to others. Thank You!

PATIENT ACKNOWLEDGEMENT AND CONSENT FORM - CONTACT: Heather Sutton

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides safeguards to protect your privacy; which was implemented on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office and copies are available for your convenience. What this is all about: Specifically, there are rules and restrictions on who my see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the US Department of Health and Human Services. I hereby authorize the professional office named above, its director, administrative staff and clinical staff or assignees, medical information services and billing departments to release any and all medical and dental records and information from my date of birth to the present, unless specified otherwise, relating my care and treatment (including x-rays, photographs, electronic and digital files, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services). I understand this consent shall remain in force from this time forward.

PATIENT ACKNOWLEDGEMENT AND CONSENT: I HAVE READ AND UNDERSTOOD THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE AND CONSENT THE DISCLOSURE OF MY HEALTH INFORMATION AND/OR MY MINOR CHILDREN'S TREATMENT AS DESCRIBED IN THIS FORM AND/OR THE NOTICE OF PRIVACY PRACTICES.

Patient Name(s)	Signature of Patient, Parent or Legal Guardian
Parent Name (please print)	Date