PATIENT INFORMATION

Name _____
Last First Middle Initial

Gender: □Male □Female Date of Birth ____/____/____ Social Security#_____-_____-_____

Address _____
Street City State Zip Code

Home Phone _____ Cell Phone _____

**In the event we are unable to contact you personally, please initial giving us consent to leave a message on your answering machine regarding your child's appointment.* (Initial) _____

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone_____

How did you hear about our Office? (please check only one)

❑Friend/Relative ❑ Insurance Plan ❑ Internet ❑Newspaper ❑Other_____

If you were referred, whom may we thank for referring you? _____

PARENT/GUARDIAN INFORMATION

Father/Guardian Name _____ Mother/Guardian Name _____
Last First Middle Initial Last First Middle Initial

Cell_____ Cell_____

Email_____ Email_____

**If email is provided, we may contact you for appointment reminders/account information*

Parent(s) are: ❑Married ❑Divorced ❑ Single ❑Widowed ❑ Partners

Child lives with: ❑Both parents ❑ Mother ❑Father ❑Legal guardian ❑other_____

DENTAL INSURANCE INFORMATION

Primary Insurance

Insurance Co. Name _____ Phone_____ Group/Policy #_____

Insured's Name _____ Insured's Date of Birth_____ Relation_____

Insured's SSN/ID #_____ Insured's Employer Name_____

Secondary Insurance

Insurance Co. Name _____ Phone_____ Group/Policy #_____

Insured's Name _____ Insured's Date of Birth_____ Relation_____

Insured's SSN/ID #_____ Insured's Employer Name_____

Person responsible for payment (Name) _____Relation_____

DENTAL HISTORY

Reason for this visit:

❑ Checkup/Cleaning ❑ Dental Caries ❑ Mouth injury ❑ Toothache ❑ Crooked teeth ❑ Oral Habits

❑ Others_____

Last Dental Visit and Reason_____ Dentist's name_____

Any unhappy dental experience? _____

How do you think your child will behave during this visit: ❑ Friendly ❑ Happy ❑ Anxious ❑ Timid ❑ Afraid ❑ Resistant

Does your child ever have any of the following:

❑ Thumb or Finger sucking ❑ Tongue Thrusting ❑ Mouth breathing ❑ Lip/Nail biting

MEDICAL HISTORY

Patient's Pediatrician Name_____ Phone_____

Yes □ No □ Is your child under the care of a physician now?
If yes, please explain: _____

Yes □ No □ Has your child been hospitalized or had any surgeries?
If yes, please explain. _____

Yes □ No □ Is your child taking any kind of medication at this time? If yes, please list:

Drug	**Dose/Frequency**	**Reason for taking**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes □ No □ Is your child allergic to any medications or substances? If yes, please check box below:

□LIDOCAIN □MEPIVACAIN □PENICILLIN □CODEIN □ASPIRIN □SULFA □LATEX
□Other _____

Has your child had any history of:

□ Anernia	□ Cerebral Palsy	□ Heart disease	□ Premature baby
□ Asthma	□ Convulsions	□ Heart Murmur	□ Problems with anesthesia
□ Autism	□ Developmental Delay	□ Hearing Problems	□ Prolong bleeding when cut
□ ADHD	□ Diabetes	□ Hepatitis/Liver Disease	□ Rheumatic fever
□ AIDS/HIV	□ Down Syndrome	□ High/Low blood pressure	□ Seasonal Allergies
□ Birth defect	□ Epilepsy	□ Kidney disease	□ Tuberculosis
□ Blood disorder	□ Ear, eye, nose trouble	□ Lung disease	□ Thyroid Disease
□ Cancer	□ Gastric reflux	□ Other: _____	

PATIENT AGREEMENT

- ☐ I authorize Pacific Dental Care, P.C. to verify and release any medical or dental information to process my insurance claims.
- ☐ I agree to inform Pacific Dental Care, P.C. of any changes in my home address, phone number, or insurance coverage.
- ☐ I understand that I am fully responsible to give the most accurate information regarding my insurance, medical or dental status. I accept responsibility for any unpaid balances do to a denial of claims as a result of inaccurate information provided.
- ☐ Deductible and co-pay are expected at time of service unless prior arrangement was made. A **$50** will be charged for check return due to insufficient funds.
- ☐ I was informed about the "no-shows or within-24-hours cancellation" policy. Violation of this policy will result in a **charge of $30 per an appointment** or **discontinuation of service**. For OHP patients, discontinuation status will be reported to ODS or CDC. This may result in a disqualification in my future coverage.
- ☐ I am aware not all dental procedure is covered by OHP (Oregon Health Plan) dental insurance. Therefore, our office will not perform those procedures for patients who have OHP, unless I sign a wavier to be financially responsible for those non-covered procedures/services.
- ☐ While Pacific Dental Care, P.C. will attempt to contact me for appointment confirmation, it is my responsibility to call to confirm, or cancel, the appointment 24 hours in advance.
- ☐ We require 2-4 weeks to process any request (include refund for any type of service) from patient after a written request is received.
- ☐ I acknowledge this office Notice of Privacy Practices and understand it.

_____/_____
Parent/Guardian Signature **Date**

_____/_____
Dr/Hyg Signature **Date**