Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
(Last / First / MI)

Child's Birthdate: ___/___/___ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Child's Home #: (____)_____ SS #: _____

Child's Home Address: _____
(Apt / Condo #)

_____
(City / State / Zip)

Email Address: _____

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Is child adopted? ☐ Yes ☐ No Is child in a foster home? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Other siblings seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Parent's Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered ☐ Separated

3 Parent's Information

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

☐ **Father** ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ___/___/___

Email Address: _____

Cell #: (____)_____ Hm #: (____)_____

Employer: _____ Wk #: (____)_____

SS #: _____ DL #: _____

4 Person Responsible for Account

Name: _____ Relation: _____

Billing Address: _____

_____
(City / State / Zip)

Wk #: (____)_____ Ext: _____ Hm #: (____)_____

Employer: _____

DL #: _____ SS #: _____

Who is responsible for making appointments?

Name: _____

Wk #: (____)_____ Ext: _____ Hm #: (____)_____

5 Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

6 Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ ID #: _____

Policy Owner's Employer: _____

Employer's Address: _____

Orthodontic Coverage? ☐ Yes ☐ No

CONTINUED ON BACK

7 Why did you bring the child to the dentist today? _____

_____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ☐ Yes ☐ No

Please list all drugs that the child is currently taking:

_____

_____

Aside from items listed below, list all drugs/things the child is allergic to:

_____

_____

Latex ☐ Yes ☐ No Metals/Nickel ☐ Yes ☐ No Plastic ☐ Yes ☐ No

8 Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Handicaps / Disabilities
Y	N	ADD / ADHD	Y	N	Hearing Impairment
Y	N	Anemia	Y	N	Heart Murmur
Y	N	Any Hospital Stays	Y	N	Hemophilia
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Artificial Bones/Joints/Valves	Y	N	Hives
Y	N	Asthma	Y	N	HIV+ / AIDS
Y	N	Cancer	Y	N	Kidney / Liver Problems
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	Mononucleosis
Y	N	Convulsions	Y	N	Rheumatic / Scarlet Fever
Y	N	Diabetes	Y	N	Sickle Cell Disease / Traits
Y	N	Epilepsy	Y	N	Skin Rash
Y	N	Exposed to HIV, but Neg.	Y	N	Tuberculosis (TB)

Are the Child's Immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems that the child has had: _____

_____

Does/did the child experience any of the following?

Y	N	Lip Sucking / Biting	Y	N	Nursing Bottle Habits
Y	N	Nail Biting	Y	N	Thumb / Finger Sucking

Was the child breast fed? ☐ Yes ☐ No

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

My method of payment will be: _____

_____
Signature of parent or guardian Date

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY **OFFICE USE ONLY** OFFICE USE ONLY **OFFICE USE ONLY**

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein. Initials: _____ Date: _____

Doctor's Comments:

_____

_____

_____

_____

Medical History Update

1. Date: _____ **Signature:** _____

Comments: _____

_____

2. Date: _____ **Signature:** _____

Comments: _____

_____

The Family Dentist
Changing Lives One Smile at a Time!

THE FAMILY DENTIST
Dr. Ron O'Neal
7401 Dr. Martin Luther King Jr. Street North
St. Petersburg, Florida 33702

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Ronald B. O'Neal, D.M.D., may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Ronald B. O'Neal, D.M.D., P.A.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Ronald B. O'Neal, D.M.D., P.A., reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Ronald B. O'Neal, D.M.D., P.A.'s Privacy Officer at 7401 Dr. MLK Jr. Street North, St. Petersburg, Florida 33702.

With my consent, Ronald B. O'Neal, D.M.D., may call my home or other designated location to leave a message on voicemail in reference to any items that assist the practice in carrying out TPO, such as appointment confirmations, insurance items, and any call pertaining to my clinical care.

With my consent, Ronald B. O'Neal, D.M.D., may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment confirmation cards and patient statements.

With my consent, Ronald B. O'Neal, D.M.D., may email or fax to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment confirmations.

I have the right to request that Ronald B. O'Neal, D.M.D., restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions; but if it does agree, it is bound by this agreement.

By signing this form, I am consenting to allow Ronald B. O'Neal, D.M.D., the use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Ronald B. O'Neal, D.M.D., may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian
If under 18, Patient or Guardian Must Sign

Date

_____

Print Name of Patient or Legal Guardian