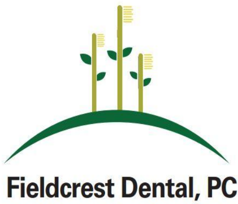

Child Patient Health History

How did you hear about us? ______________________________
Name or source

Date:_____________________

Patient Name: ____
Last **First** **Middle**

Mailing Address: ____
House number & PO Box if applicable **City** **State** **Zip Code**

Email address:____

Home Phone: (_____) _______________________ Cell Phone: (_____) _______________________

Date of Birth: __________________________________ Male / Female (circle one)

Do you have Dental Insurance? Yes / No
If so, Name of Insurance Company: ________________________________Member ID #:_____________________

Father's Information

Father's Name: ____
Last **First** **Middle**

Date of Birth: ______________________________ Social Security Number: ________________________

Employer: ____ Position: ____________________________
Business name **City & State**

Name of Dental Insurance Company: ____

Policy/Group number: ______________________________ Member ID number: ___________________________

Mother's Information

Mother's Name: ____
Last **First** **Middle**

Date of Birth: ______________________________ Social Security Number: ________________________

Employer: ____ Position: ____________________________
Business name **City & State**

Name of Dental Insurance Company: ____

Policy/Group number: ______________________ Member ID number: ______________________

Who is responsible for this account: ____

Emergency contact Person: ____
Name **Relationship** **Phone#**

List All Medications You Are Currently Taking:

____

____

____

List All Previous Surgeries with Dates:

____

____

Any Medicines You Are Supposed To Be Taking, But Aren't? ______________________________

Is your General Health Good? Yes / No (if no, why) ______________________________

Currently under Doctors Care? Yes / No (if so, why) ______________________________

Physician's Name ______________________________ Phone # ______________
Name **City & State**

Are you allergic to any of the following?

Penicillin *Yes/No* **Codeine** *Yes/No* **Acrylic** *Yes/No* **Metal** *Yes/No* **Latex** *Yes/No*

Sulfa Drugs *Yes/No* **Other:** ______________________________

Please list any dental/oral concerns ______________________________

Please circle any of the following conditions that you have currently or have had in the past:

Cardiovascular
Angina/Chest Pain
Congenital Heart Problems
Heart Attack / Failure
High / Low Blood Pressure
Heart Surgery / Artificial Valve
High Cholesterol
Infective Endocarditis
Irregular Rhythm / Pacemaker
Murmur
Rheumatic Fever

Blood
Anemia
Hemophilia

HIV / AIDS
Bruise Easily / Thin Blood
Organ Transplant (Received or Donor)

Respiratory
Asthma
COPD
Easily Winded
Emphysema
Frequent Sinus Trouble
Other Breathing Problems
Tuberculosis

Neural / Neurovascular / Psych
Alzheimer's / Dementia
Anxiety / Depression
Epilepsy / Seizures
Fainting / Dizzy Spells
Glaucoma

Neuralgia
Psychiatric Care (Other) ______________
Stroke

Liver/Kidney/Gastro-Intestinal
GERD (Acid Reflux)
Hepatitis
Kidney Problems
Liver Disease (Other)
Ulcers

Musculoskeletal
Arthritis / Gout
Artificial Joint
Bone / Muscle Other ______________
Osteoporosis

Cancer
Cancer (Type) ______________

Chemotherapy
Radiation Therapy

Immune System: Diabetic Type 1 or 2

Please be sure to read, sign and date of all the bottom approvals.

Patient, Parent or Guardian:

This information has been answered to the best of my knowledge, and I will update Dr Hamper, DMD and their staff of any medical changes in the future. My signature authorizes the release of information to my insurance company and it authorizes assignment of benefits when applicable.

Signature: ________________________________ Date: ____________________________

Patient, Parent or Guardian:

I hereby agree to the following terms and conditions:

There is a 5% annually late charge assessed on all balances after 90 days past due. Checks, which are declared non-sufficient funds, will be charged a $25.00 service fee. Also, the undersigned agrees to pay collections fee of 30% of the total owed when sent to collections. All attorney fees and court costs incurred by the creditor. All the information provided is correct.

I have read and understand the above paragraph in its entirety.

Signature: ________________________________ Date: ____________________________

Patient, Parent or Guardian:

NOTICE OF PRIVACY PRACTICE

I have received a Notice of Privacy Practice

Patient name (print) _____________________________________

Signature: ________________________________ Date: ____________________________

Patient unable or refused to sign acknowledgement

Appointment Cancellation Guidelines

We strive to provide excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an appointment cancellation guideline so that we can meet the needs of all of our patients. When an appointment is scheduled, that time has been set aside especially for you and when it is missed, that time cannot usually be used to treat another patient.

Our policy is as follows:

We require **48 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a failed appointment. We care about you and hope it never comes to this, but we allow **2 failed appointments** in any 2 year period before we ask that you establish yourself at another dental office. We do this because the number of patients that cannot be seen due to failed appointments is too great.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have. This guide is our north star, but we also reserve the right to alter these guidelines as needed in extenuating circumstances.

We thank you for your trust in us and value our continued relationship.

I, ____, have read and understand the above notice.
Print Name