Banks
PEDIATRIC DENTISTRY

Dr. Brian Banks
2500 S. Power Rd. Ste. 128
Mesa, AZ 85209
480-699-8082

New Patient Medical History

Child's Last name: _____Child's First name: _____ Sex: M F

Purpose of visit: _____Concerns:_____Birthdate:_____

Child's Interests: _____Name of Pet(s):_____

Does your child have any special needs? _____Who may we thank for referring you to us?_____

Health History

Child's Pediatrician: _____Phone number: (_____)_____Last Physical:_____

Is your child under a physician's care now? Y N If yes, reason: _____ Immunization up to date? Y N

Is your child taking any medications currently (including over the counter)? Y N If yes, please list:_____

Is your child allergic to any medication? Y N If yes, please list: _____

Any history of hospitalization or surgery: (if yes, when)_____

Does your child have allergic reaction to: (if yes: please check all that applies)

___Peanuts/Tree nuts	___Soy	___Wheat/Gluten	___Pollen/Dust/Environmental	___Anesthetics
___Eggs	___Metals	___Animals	___Berries	___Acrylic
___Milk	___Wheat/Gluten	___Dyes/Coloring	___Others:_____	

Has your child had a history or difficulty with any of the following?

ADHD/ADD	Y N	Chemo/Radiation Therapy	Y N	Hepatitis	Y N
AIDS/HIV	Y N	Cystic Fibrosis	Y N	Kidney	Y N
Artificial Heart Valves	Y N	Delayed Development	Y N	Liver	Y N
Asthma	Y N	Depression/Anxiety	Y N	Murmur	Y N
Allergies to Medications	Y N	Diabetes	Y N	Muscular Disorder	Y N
Autism	Y N	Down's Syndrome	Y N	Premature Birth	Y N
Bleeding Disorder/Bruising	Y N	Earaches/Infections	Y N	Speech Disorder	Y N
Cancer/Malignancy	Y N	Emotional/School Problems	Y N	Sinusitis	Y N
Cardiac Disease/Heart	Y N	Epilepsy/Seizure	Y N	Tuberculosis	Y N
Cerebral Palsy	Y N	Hearing Impaired	Y N	Visual Impaired	Y N

Other:_____

Dental History

Is this your child's first dental visit? Y / N. If no, previous dentist: _____ Phone number: (_____)_____

Date of last visit: _____ How was his/her experience? _____ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: _____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: _____

Has your child done any of the following (past or present)?

Please circle: thumb/finger-sucking pacifier nail biting lip sucking mouth-breathing snoring teeth grinding nursing bottle-feeding

Is your water fluoridated? Y N Does your child use fluoridate toothpaste? Y N

How often does your child brush his/her teeth? _____ With adult supervision? Y N How often does your child floss? _____

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Patient Registration Form

Child's Name: _____ M / F Birthdate: _____

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Child's Name: _____ M / F Birthdate: _____

Father (full name) _____

SSN:_____ Birthdate:_____

Address: _____

City:_____State:_____ Zip:_____

Home Phone: (_____)_____

Cellular Phone: (_____)_____ _____

Father's Employer: _____

Business Address:_____

Work Phone: (_____)_____

E-mail Address:_____

Mother (full name) _____

SSN:_____ Birthdate:_____

Address: _____

City:_____State:_____ Zip:_____

Home Phone: (_____)_____

Cellular Phone: (_____)_____

Mother's Employer: _____

Business Address:_____

Work Phone: (_____)_____

E-mail Address:_____

How would you like us to contact you? Home Work Cell E-mail

Parent(s) are: Married____ Divorced____ Single____

Child lives with: both parents mother father other

Person financially responsible for child's dental care:_____

Emergency Contact:_____Phone: (_____)_____

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE:_____Relationship:_____Date:_____

Dental Insurance Information

Do you have dental insurance coverage for your child? Y N

Primary Insurance Company: _____ Group Number:_____

Insurance Company Address: _____ Insurance Company Phone #: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Employer: _____ Subscriber's ID#: _____ Subscriber's SSN: _____

Do you have secondary insurance coverage? Y N

Secondary Insurance Company: _____ Group Number:_____

Insurance Company Address: _____ Insurance Company Phone #: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Employer: _____ Subscriber's ID#: _____ Subscriber's SSN: _____

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HIPAA PRIVACY PRACTICES CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Banks Pediatric Dentistry has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Banks Pediatric Dentistry at any time at the above address to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Banks Pediatric Dentistry restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____ Birthdate:_____

Parent or Legal Guardian: _____ Birthdate:_____

Parent or Legal Guardian Signature: _____ Date: _____

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LEGAL CONSENT TO MAKE DECISIONS

As a convenience, we would like to offer you a chance to provide us with a list of individuals that may accompany your child to subsequent visits. With this list, a family member, step-parent, or good friend would have the authority to accompany your child to a dental appointment and make decisions without the need of any additional written or oral consent from you. If not listed, patients must always be present with a parent or legal guardian. Please only provide the names of those individuals that you trust to make such decisions as treatment changes, payments, and to discuss medical and financial information.

We, as a HIPAA compliant healthcare office, will use our best discretion to maintain all personal information and will only provide the individuals listed below with information needed to make specific decision on your behalf. Information will only be provided on a need to know basis and we will not allow these individuals to have or copy your child's dental chart. We simply want to make treating your child at our office as convenient as possible for you.

Please identify such individuals and your decision to allow them to provide consent to treatment decisions, to make financial arrangements, or both. Please also remember any individuals accompanying your child to an appointment will also be responsible for additional charges incurred during that particular visit.

Patient's Name: _____

Individual's Name	Treatment	Financial
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

As the parent or legal guardian of the patient noted above, I do hereby provide the individuals listed the legal authority to make decisions in my absence. I also understand that these decisions may change treatment recommendations or charges that I have already agreed to and that I, as this child's parent or legal guardian, am ultimately responsible for any new charges incurred as a result of treatment changes.

Parent or Legal Guardian: First Name:_____ Last Name:_____ Birthdate:_____

Parent or Legal Guardian: _____ Date: _____

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Financial Agreement

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. Patients with dental insurance must provide accurate and complete insurance information so we may assist you in filing your claim promptly. You will be required to pay your portion the day of dental treatment. For patients without insurances: payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month, or a monthly late charge of $10 will be added to unpaid balances over 30 days past due and where appropriate.

Patient Name: _____ Birthdate:_____

Parent or Legal Guardian: _____ Birthdate:_____

SIGNATURE:_____Relationship:_____Date:_____

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our NOTICE OF PRIVACY PRACTICES, but acknowledgment could not be obtained because of:

___Individual refused to sign ___Communication barriers prohibited obtaining the acknowledgement ___An emergency situation prevented us ___Acknowledgment not returned by parent. HIPAA information given

Medical and Dental History Reviewed Verbally with Parent/Guardian for Patient Named Above: Initial _____Date:_____