

NEW PATIENT FORM

Please complete all the fields below.

PATIENT INFO

Child's Name _____

Nickname _____ Sex: M F

Date of Birth ____/____/____

Address _____

City _____ State _____ Zip _____

RESPONSIBLE PARTY INFO

Mother (full name) _____

SSN _____ DOB _____

Cell _____

Work _____

Father (full name) _____

SSN _____ DOB _____

Cell _____

Work _____

Home _____

Email _____

Purpose of Visit _____

Concerns? _____

Name & Ages of Siblings _____

Is Your Child Adopted? Yes No

Does your Child Have Any Special Needs?

Any Phobias? _____

Child's School _____

Who can we thank for referring you to us?

A PARENT OR LEGAL GUARDIAN MUST
ACCOMPANY YOUR CHILD ON THIS FIRST VISIT.

HEALTH HISTORY

Child's Pediatrician _____

Kaiser # (if applicable) _____

Last Physical ____/____/____

Pediatrician's Phone Number _____

Pediatrician's Address _____

Is your child under a physician's care now? Yes No

If Yes, Reason _____

Immunizations up to date? Yes No

Current Medications? Yes No

If yes, Please List _____

Allergic to Medication? Yes No

If yes, Please List _____

Child have an allergic reaction to any of the following?

Foods Pollen Dust Latex Eggs Soy

Other? _____

Child had a history or difficulty with any of the following?

TMJ Problems

Speech Disorder

Bleeding

Brain Injury

Liver/Jaundice

Tuberculosis

Heart

Bruising

ADHD/ADD

Seizures

Down's Syndrome

Arthritis

Cerebral Palsy

Hearing

Bone Disorder

Bladder

Eating Disorder

Snoring

Premature Birth

Diabetes

Sinus Problems

Allergies to Medications

Hepatitis

Ear aches/Infections

Immune Disorders

Rheumatic Fever

Cancer/Malignancies

Autism

Depression/Anxiety

Kidney

Delayed Development

Asthma

Nosebleeds

Last Asthma Attack: _____

Emotional/School Problems Other: _____

If yes to any, please explain _____

JOSHUA R. TWISS D.D.S.

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DENTAL HISTORY

Is this your child's first dental visit? Yes No

If No, Previous Dentist _____

Previous Dentist Phone _____

Date of Last Visit ____/____/____

How was his/her experience? _____

Were any x-rays taken? Yes No

Child's attitude towards the dentist or dental care _____

Child had any injuries to teeth, mouth, or head? Yes No

If yes, please describe _____

Does your child have any of the following habits?

Thumb/Finger Pacifier Nail Biting Lip Sucking

Mouth-breathing Snoring Teeth Grinding

Nursing Bottle-feeding

Is your water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child use fluoridated toothpaste? Yes No

How often does your child brush his/her teeth? _____ x/day

How often does your child floss? _____ x/day

With adult supervision? Yes No

How may we help to make this visit a positive experience for your child? _____

I hereby give the dentist permission to complete an oral exam and radiographs (x-rays) for diagnostic purposes. I understand this visit will include a cleaning and fluoride treatment, as well. 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.

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. This office is not responsible for any insurance company's arbitrary determination of payment, which procedures are covered under the plan, frequency of procedures performed, or period of time taken to process claims. You are responsible for payment in full regardless of any insurance you may have. As a courtesy to you, we will complete and file insurance forms relative to dental treatment and will do our best to collect all fees due from your insurance carrier. However, fees not paid by your insurance company within 60 days are due and payable by the patient's parent or guardian. I realize that the failure to keep this account current may result in the dentist being 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 will be applied to unpaid balances over 60 days past due and where appropriate, a credit bureau report may be obtained. In case of default on payment of this account, I agree to pay the collection costs and reasonable attorney fees incurred in attempting to collect on this account of any future outstanding account balances. I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

INSURANCE INFORMATION

Do you have dental insurance coverage for your child? Yes No

Father's Dental Insurance Company _____

Insurance Phone _____

Insurance ID Number _____

Group or Policy Number _____

Mother's Dental Insurance Company _____

Insurance Phone _____

Insurance ID Number _____

Group or Policy Number _____

SIGNATURES

RESPONSIBLE PARTY POLICY:

Because of a large percent of the population involves a divorce situation, it is the policy of this office to collect from the parent who brings the child in for dental services.

OFFICE POLICIES:

Unless appointments are cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. We do attempt to confirm appointments, but do so only as a courtesy. The Parent/Guardian is ultimately responsible for any scheduled appointments made for the child.

I acknowledge that I have read and agree to the above policies:

SIGNATURE

Relationship _____ Date ____/____/____

Acknowledgment of receipt of NOTICE OF PRIVACY PRACTICES (HIPAA) *You may refuse to sign this portion of the acknowledgment* I, _____ have received a copy of or have had the opportunity to review this office's NOTICE OF PRIVACY PRACTICES (HIPAA).

PRINT NAME

SIGNATURE

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