Right Touch Dental Center

502-244-0007

Tell us about your child

Child's Name _____ Nickname _____
Last First MI

Phone # (H) ( ) _____-_____ (O) ( ) _____-_____ ☐ Female ☐ Male

Child's Birthday ____/____/_____ Grade_____ School _____

Child's home address _____

Who is responsible for making appointments? _____

Will there be any other adults bringing the child? _____

Other family members seen by us _____

Whom may we thank for referring you?

☐ Name_____ ☐ Special Mailing ☐ 1-888-SMILE INFO
Patient/ Doctor/Specialist

☐ Internet ☐ Sign Out Front ☐ Television ☐ Phonebook ☐ Other _____

Mother's Name _____ ☐Step Mother ☐ Guardian Birth date ___/___/_____

Address_____City _____ State _____ Zip _____

SS# _____ Drive Lic.#_____Home #_____Cell #_____Work_____

Father's Name _____ ☐Step Father ☐ Guardian Birth date ___/___/_____

Address_____City _____ State _____ Zip _____

SS# _____ Drive Lic.#_____Home #_____Cell #_____Work_____

Parent's Martial Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed
☐ Other (Special family circumstances) _____

Person Responsible for the Account Name _____

_____ _____
Insured's Name SS# Insurance Company Phone#

_____ _____
Address City State Zip

_____ _____
Group# ID# Birth date Insured's Employer

{Please inform us of any secondary insurance**}**

Why did you bring the child to the dentist today?

_____

Any pain…….Where? _____

Is this the child's 1st visit to a dentist? ☐ Yes ☐ No
Has the child ever had a difficult dental visit or a problem associated w/ a dental visit? ☐ Yes ☐ No
If yes, please explain_____
Are you opposed to fluoride? ☐ Yes ☐ No
Has the child ever had trauma to the face, head, or any teeth? ☐ Yes ☐ No
Does your child have any discoloration on teeth (dark spots or white spots)? ☐ Yes ☐ No

Has the child ever had any pain or tenderness associated with the jaw joint? (TMJ / TMD)? ☐ Yes ☐ No

How often does the child: brush _____ per day? Floss _____per week?

Please describe the child's emotional state in regards to their dental appointment today?

(Calm, fearful, angry, happy, concerned, curious, shy, brave, or other) _____

Has the child ever had any of the following medical conditions?

☐ Yes ☐ No Abnormal Bleeding	☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No ADD/ADHD	☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Artificial bones/joints	☐ Yes ☐ No Hepatitis
☐ Yes ☐ No Asthma	☐ Yes ☐ No Hospitalizations
☐ Yes ☐ No Blood pressure problems	☐ Yes ☐ No Hives
☐ Yes ☐ No Cancer	☐ Yes ☐ No HIV+
☐ Yes ☐ No Congenital Heart Defect	☐ Yes ☐ No Kidney/Liver problems
☐ Yes ☐ No Convulsions/Epilepsy	☐ Yes ☐ No Mononucleosis
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Rheumatic/Scarlet Fever
☐ Yes ☐ No Handicaps/ Disabilities	☐ Yes ☐ No Sickle cell Disease Trait
☐ Yes ☐ No Hearing impairment	☐ Yes ☐ No Tuberculosis (TB)
Child's overall physical health ☐ good ☐ fair ☐ poor	Other_____

Please list all medications (prescription, over-the-counter, herbal supplements, vitamins and minerals).

_____
_____

Please list all allergies:

_____

Please discuss any serious medical problems that the child has had.

_____

Does the child have any of the following habits?

☐ Yes ☐ No - Thumb/Finger Sucking
☐ Yes ☐ No - Lip sucking/biting
☐ Yes ☐ No - Chewing on objects
☐Yes ☐ No - Mouth breather
☐ Yes ☐ No - Nail biting
☐Yes ☐ No - Nursing bottle habit (sleeping with a bottle)
☐ Yes ☐ No - Used pacifier
☐ Yes ☐ No - Speech problem
☐ Yes ☐ No - Tongue thruster

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.

_____ _____

Signature of parent or guardian **Date**

*I understand that the information I have given today is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence.

*Right Touch Dental Center is HIPAA compliant. I am providing this practice w/ my authorization to use and disclose my protected health care information for the purpose of necessary treatment, payment from a third party payee, and health care operations as described in the Privacy Notice. RTDC is committed to meeting and exceeding the standards of Infection Control mandated by OSHA, the CDC, and the ADA. _____

Initials of parent or guardian

***Payment is due in full** at the time of treatment, **unless** prior arrangements have been approved. Any unpaid balances may be subject to a finance fee or late charge if payment is not received in a timely manner.

*The patient, parent and/or guardian **must give 24 hour notice**. **There is a $50 per hour fee** for each hour of scheduled appointment time missed ($100 for 2 hours). _____

Initials of parent or guardian

*I understand that I am responsible for all costs of dental treatment.

*If this office accepts my insurance, I understand that **I am responsible for payment of services rendered** and/or **responsible for paying any co-payments** and **deductibles that my insurance does not cover**.

* I herby authorize payment directly to Right Touch Dental Center of the group insurance benefits otherwise payable to me.

_____ _____

Signature **Date**

I verbally reviewed medical /dental information with patient, parent and/or guardian.

Staff_____ Date _____

Doctor_____ Date _____

_____

_____

_____