Fisher Family Dental

308 N. Main St • DeForest, WI 53532 (608)842-0699

New Patient Information

Please let us know about your child's medical and dental history so we may serve you more effectively and in a manner that helps with the overall health and well-being of your child.

We realize that not all questions will pertain to your child. If you have questions, please ask and we will help to better explain the question.

Chart#: _____ FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI)

_____ (Preferred Name)

Title: **Gender:** _____ (Mr/Ms/Mrs/etc) ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

Prev. Visit: _____

Email Address: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext)

Best time to call: _____

Address: _____ (Address 1)

_____ (Address 2)

_____ (City) _____ (State) ___-____ (Zip Code)

Who does the child live with?

☐ Mother ☐ Father ☐ Guardian ☐ Grandparents

Siblings who are or who have been a patient in our office:

_____

_____

Is there anything that you would like to discuss with the Dentist in private, alone, or away from your child? ◯ Yes ◯ No

What is the reason for seeing the dentist today?

☐ First Visit ☐ Check-up ☐ Pain ☐ Other

Whom may we thank for referring you to our practice? Please mark the correct box and name them below.

☐ Another Dental Office ☐ Phonebook ☐ Friend ☐ Driving by ☐ Internet ☐ School

☐ Work ☐ Other (name below):

_____

Guardian Information

Unless information is different, this form need only be completed for one child.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ (Last) _____ (First) ___ (MI)

_____ (Preferred Name)

Title: **Gender:** _____ (Mr/Ms/Mrs/etc) ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

SS#: **DL#:** ___-__-____

_____

Email Address: _____

Best time to call: _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext)

_____ (Fax) _____ (Other)

Address: _____ (Address 1)

_____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Employer

_____

_____

Other Guardian Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ Last _____ First ___ MI

_____ Preferred Name

Title: **Gender:** _____ Mr/Ms/Mrs/etc ◯ Male ◯ Female

Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____

Email Address: _____

Phone: _____ Home _____ Mobile _____ Work ____ Ext

Best time to call: _____

Address: _____ Address 1

_____ Address 2

_____ City ____ State ____-____ Zip Code

Employer

_____

_____

Dental Benefits Plan

Primary

Name of Insured: _____ Last

_____ First ___ MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

_____

Plan phone number _____

Secondary

Name of Insured: _____ Last

_____ First ___ MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:

_____

Plan phone number * _____

Child's Medical & Dental History

Within the past year have there been any changes in your child's general health? ◯ Yes ◯ No

Your child's pediatrician name, phone number and date of last exam:

_____

_____

Please indicate if your child has experienced any of the following.

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Venereal Disease
- ☐ *Pre-Med - Clind
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ *Pre-Med - Other
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers

- ☐ Had complications with or after dental treatment.
- ☐ Has been seen by a cardiologist.
- ☐ Taking any prescription or non-prescription medications.
- ☐ Any other conditions, diseases, etc. not listed above.
- ☐ Currently under the care of a physician due to a specific condition.
- ☐ Been admitted to a hospital in the last 5 years due to a surgery or illness.
- ☐ Tobacco use (chewing or smoking.)

If any of the previous questions are marked, please explain:

_____

_____

Has your child been to a different dental office in the last 6 months?
What was done at your child's last dental visit, if to a different office?

_____

_____

How frequently does you child brush their teeth?

☐ 3+ a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom ☐ By parent ☐ By child ☐ Both

Is your child taking a fluoride supplement? ◯ Yes ◯ No

How often does your child floss?

☐ Once daily ☐ Occasionally ☐ Never ☐ By parent ☐ By child

Does your child do any of the following?

☐ Lip sucking/biting ☐ Pacifier ☐ Nail biting ☐ Finger/thumb sucking ☐ Nursing/bottle ☐ Grinds his teeth ☐ Snores

☐ ***To the best of my knowledge, all of the preceding information is true and correct. If there is any change in my child's health I will inform the office at my child's next dental appointment.**

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Dental Practice Financial Policy

The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient will be determined before treatment.

We will collect all payments (co-payments) at time of service.
We file Insurance as a courtesy to our patients.
The patient portion we collect at the time of service is only an estimate and there may be additional monies owed after insurance pays.

There are no discounts that can be given with Insurance or Membership Plans.

Signature of guarantor of payment/responsible party:

Signature:_____

Notice of Privacy Practices Acknowledgment.

The privacy of your health information is important to us. Our Notice of Privacy Practices describes how your health information will be handled in various situations.

We ask that you sign this form to acknowledge that you received a copy of our Notice of Privacy Practices.

We will release your information to your dental insurance for authorization and payment, specialists that you may referred to for care, or any other person you so wish and list below:

_____

_____

Signature of patient, parent, or guardian (responsible party):

Signature_____

☐ **By checking this box, I acknowledge that I have read, and fully understand and agree to the terms of this Financial Policy and HIPAA**