FISHER FAMILY DENTAL
308 N. Main Street, DeForest, WI 53532 608-842-0699

Child New Patient Information

Patient Name:

Last: _____ First: _____ M.I.: ____ Preferred: _____

Gender: _____ Birthdate: _____

Phone number to call: _____(H) _____(W) _____(C)

Who does the child live with? ☐Both Parents ☐Mother ☐Father ☐Guardian ☐Grandparents

Parent/Guardian Information:

Name: _____

Address: _____

Email: _____

Signature: _____

Parent/Guardian Information:

Name: _____

Address: _____

Email: _____

Signature: _____

Insurance Information:

Name of Policy Holder: _____ D.O.B: _____

Policy Holder ID Number: _____ Group #: _____

Name of Insurance: _____ Insurance Phone #: _____

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

Comments or concerns: _____

_____

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

Whom may we thank for referring you to our office: _____

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Child's Medical & Dental History

Patient Name: _____ **Date:** _____

Parent/Guardian Name: _____

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. Checking the box indicates a "Yes" response, leaving blank indicates a "No" response.

☐ Anxiety	☐ Dizziness/Fainting	☐ HIV	☐ Seizures
☐ Anemia/Blood Disorder	☐ Epilepsy	☐ HPV	☐ Sinus Problems
☐ Arthritis	☐ Excessive Bleeding	☐ Kidney Disease	☐ Smoking/Tobacco Use
☐ Artificial Joints	☐ G.I. Problems	☐ Liver Disease	☐ Stroke
☐ Asthma	☐ Glaucoma	☐ Mental Health Condition	☐ Thyroid Problems
☐ Auto-Immune Diseases	☐ Head Injuries	☐ Migraine/Headaches	☐ Tuberculosis
☐ Cancer	☐ Heart Disease	☐ Pacemaker	☐ Tumors
☐ Chemotherapy/Radiation	☐ Hepatitis	☐ PTSD	☐ Ulcers
☐ Diabetes	☐ High Blood Pressure	☐ Respiratory Problems	☐

Are you allergic to:

☐ Amoxicillin	☐ Aspirin	☐ Codeine	☐ Other (please list below)
☐ Penicillin	☐ Sulfa	☐ Seasonal allergies	

☐ Had complications with or after dental treatment

☐ Been admitted to a hospital in the last 5 years due to injury or illness

☐ Currently under the care of a physician due to a specific condition

☐ Any other conditions, diseases, etc. not listed above

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

_____

_____

List all medications, supplements, and/or vitamins that your child is currently taking:

_____

_____

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

_____

_____

How often does your child brush their teeth?

☐ 3x per day ☐ Twice per day ☐ Once per 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 ☐ Grinding teeth ☐ Snores

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Dental Practice Financial Policy

Print name: _____

The practice depends upon reimbursement from patients for the costs incurred in their care. We file insurance as a courtesy to our patients.

1. We will collect all payments (co-payments) at time of service. The patient portion we collect at the time of service is only an estimate and there may be additional payment owed after insurance pays.
2. If an appointment is missed or cancelled, a fee will be assigned to the patient's account. This fee will be $50 per appointment.
3. If a balance on an account goes past 90 days, a finance charge of 1.5% per month or 18% per year will be added.
4. There are no discounts that can be given with Insurance or Membership Plans.

Signature of patient or responsible party: _____

Date: _____

Notice of Privacy Practices Acknowledgment.

The privacy of your health information is a top priority. 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 be referred to for care, or any other person you so wish and list below:

_____

I consent to receive electronic information from Fisher Family Dental.

Signature of patient or responsible party: _____

Date: _____