Bippo's Place FOR SMILES

Great Fun . . .Great Smiles

PATIENTS INFORMATION

Name _____ Nickname_____ ❑Male ❑Female SS# _____

Date of Birth _____ Age _____ Race _____ Language Spoken _____

Pediatrician _____ Pediatrician's Phone # _____

Name(s) and Age(s) of siblings in our practice_____

Referred to us by_____Name of School_____

CONFIRMING INFORMATION

Which is the best contact number? ❑home:_____ ❑cell:_____

Can we call you at work? ❑yes ❑no If yes, work number _____ Name_____

E mail Address to confirm appointment _____

PARENT OR LEGAL GUARDIAN INFORMATION

Do you have dental insurance? ❑yes ❑no

Person responsible for payment _____ Social Security # _____

Father or legal guardian_____ Mother or legal guardian_____

Address _____ Address _____

City _____ City _____

Zip _____ Phone _____ Zip _____ Phone _____

Employed by _____ Employed by _____

Marital Status ❑Married ❑Widowed ❑Separated ❑Divorced ❑Single

PATIENT MEDICAL HISTORY

Is your child adopted? Yes No Foster child? Yes No

Is your child in poor health? Yes No If yes, explain _____

Is your child under the care of a physician? Yes No If yes, explain _____

Has your child ever had surgery Yes No If yes, explain _____

Has your child ever had complications following dental treatment? Yes No If yes, explain _____

Is surgery contemplated? Yes No If yes, explain_____

Does your child have any health problems that need further clarification? Yes No If yes, explain_____

List all medications your child is taking _____

Last Dental Cleaning_____

Does your child have/ever had any of the following? Please check those that apply

- ❑ Acid Reflux
- ❑ ADD/ADHD
- ❑ AIDS/HIV Positive
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Autism
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Depression
- ❑ Developmentally Delayed
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ G6PD
- ❑ Glaucoma
- ❑ Growths
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Learning Disabilities
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Nervous Disorders
- ❑ Physically Impaired
- ❑ Pregnancy: Due Date_____
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Sickle Cell Anemia
- ❑ Sickle Cell Trait
- ❑ Sinus Problems
- ❑ Special Needs
- ❑ Spina Bifida
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ VP Shunt
- ❑ Allergies:
- ❑ Penicillin
- ❑ Seasonal
- ❑ Red Dye
- ❑ Other Drug Allergy:_____
- ❑ Habits:
- ❑ Alcohol Use
- ❑ Fingernail Biting
- ❑ Nicotine Use
- ❑ Substance Abuse
- ❑ Thumb/Finger Sucking

OTHER:

- ❑ _____
- ❑ _____

DENTAL HISTORY

	YES	NO
Is this the child's first visit to a dentist?	_____	_____
Do you have fluoridated water at home?	_____	_____
Have there been any injuries to teeth?	_____	_____
If yes, please explain _____		
Has child had any unfavorable dental experience?	_____	_____
Does child have any other habits?	_____	_____
Does child still take bottle or breastfeed?	_____	_____
Does parent help with oral hygiene?	_____	_____
Does child have a TOOTHACHE?	_____	_____

Signature _____ Relationship _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have read and received a copy of Bippo's Place for Smiles Notice of Privacy Practices.

_____ _____

{Please print name} – Parent Patient's name

_____ _____

Signature of Parent Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication.

- o I consent and accept the risk in receiving information via email.
- o I consent only to receiving appointment reminders via email or text.
- o I do not consent to receiving any information via email.
- o I understand that I may withdraw/change my consent at any time.

_____ _____

Signature of Parent/Legal guardian Date