



welcome

Patient's Name _____
Last First Initial Nickname Date of Birth

Parent's Guardian's Name _____

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist?YES NO
2. If not, how long since the last visit to the dentist? _____
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ...YES NO
4. Does your child eat between meals?YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum?YES NO
6. When does your child brush his/her teeth?
 Upon arising After eating any food Right after meals Before going to bed
7. How does your child receive Fluoride?
 Community water level ____ ppm Well water level ____ ppm
 Fluoride drops or tablets Fluoride rinse or gel
8. Have any cavities been noted in the past?YES NO
9. Does your child suck his/her thumb or fingers?YES NO
10. Were any teeth (baby or permanent) removed by extraction?YES NO
Was it suggested that the space be maintainedYES NO
Was an appliance placedYES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc?YES NO
If so describe _____
12. Has your child had any problem with dental treatment in the past?YES NO
13. Has anyone in the family, including parents, had orthodontics?YES NO
14. Has your child ever received a local anesthetic?YES NO
15. Has your child ever had occlusal sealants?YES NO
16. Does your child think there is anything wrong with his/her teeth?YES NO

COMMENTS

MEDICAL HISTORY

1. Does your child have a health problem?YES NO
2. Is your child under care of physician?YES NO
If yes, since when and why? _____
Phone _____
3. Name of physician _____
4. Is your child receiving any medication?YES NO
What? _____
5. Is your child allergic to penicillin, antibiotics or other drugs?YES NO
6. Is your child allergic to or sensitive to any metals or latex?YES NO
7. Does your child have other allergies?YES NO
8. Has your child had any serious illness?YES NO
When _____ What _____
9. Has your child ever had surgery?YES NO
10. Does your child have a heart murmur?YES NO
11. Is surgery contemplated?YES NO
12. Does your child experience severe or prolonged bleeding?YES NO
13. Does your child have AIDS or has he/she tested HIV positive?YES NO
14. Has your child tested positive for hepatitis?YES NO
15. Is your child subject to nervous disorders?YES NO
 Fainting? Seizures? Dizziness? Behavioral/Learning problems?
16. Does your child have frequent headaches?YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

CHILD DENTAL MEDICAL HISTORY

PATIENT NAME
PATIENT ACCOUNT NO.

HEALTH HISTORY UPDATE

Date: _____

Health Changes: _____

CURRENT MEDICATIONS _____

1 _____

2 _____

3 _____

4 _____

Physician's Name _____

Physician's Phone _____

Last Physical Exam _____

Allergies? _____

Patient Signature: _____ Staff Initials _____

Date: _____

Health Changes: _____

CURRENT MEDICATIONS _____

1 _____

2 _____

3 _____

4 _____

Physician's Name _____

Physician's Phone _____

Last Physical Exam _____

Allergies? _____

Patient Signature: _____ Staff Initials _____

Date: _____

Health Changes: _____

CURRENT MEDICATIONS _____

1 _____

2 _____

3 _____

4 _____

Physician's Name _____

Physician's Phone _____

Last Physical Exam _____

Allergies? _____

Patient Signature: _____ Staff Initials _____

Date: _____

Health Changes: _____

CURRENT MEDICATIONS _____

1 _____

2 _____

3 _____

4 _____

Physician's Name _____

Physician's Phone _____

Last Physical Exam _____

Allergies? _____

Patient Signature: _____ Staff Initials _____

AUTHORIZATION FOR USE AND/OR RELEASE OF INFORMATION:

I authorize the employees of Dr. Brad Welsh's office to share and disclose my protected health information (PHI), for example: name, radiographs, progress notes, prescriptions, photographs, images, etc) with the following individuals or organizations:

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____

I further authorize this information to be shared and discussed with: the aforementioned; my dental and/or medical insurance company; and myself by, including but not limited to: telephone, facsimile, unencrypted and/or encrypted email, encrypted and/or unencrypted portable storage media (e.g. CD, thumb drive, portable hard-drive, etc.) and/or by conventional mail, and I hereby authorize the aforementioned parties to discuss my PHI with employees of Dr. Brad Welsh's office in the same manner. I understand that some of these listed forms of communication are not secure and may be intercepted by unintended parties. If I have any objection to the sending of my PHI through unsecure channels and/or specifically desire that my PHI not be shared through unencrypted email, then I would not sign this Authorization. The Authorization for release of information from Dr. Brad Welsh's office covers all past, present and future periods of time or which I choose to revoke said authorization in writing.

I understand that I have the right to revoke this Authorization from an or all of the aforementioned entities independently.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned by any employee of Dr. Brad Welsh's office on whether or not I sign this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed name

Signature

Date

Relationship to patient if other than patient

_____ I give consent for Dr. Brad Welsh's office to leave a message on my answering machine and/or voicemail that could include personal health information for myself or one of my dependents (if applicable)

Dr. Brad Welsh's Office Financial Guidelines

Thank you for choosing Dr. Brad Welsh's office. The following are our financial guidelines. Please review, initial where indicated, sign and date at the bottom.

Insurance:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you receive your maximum allowable benefits.

Dr. Welsh will diagnose treatment based on your dental health not your insurance coverage.

We will forward any items that the insurance company may request and help in any way we can to get your claim paid. If insurance is requesting information from you; we will contact you and it is your responsibility to get the insurance company the information they require to process your claim. If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and be reimbursed when your insurance company pays. After 90 days you are responsible to pursue payment from the insurance company.

INITIAL: _____

Account Balance:

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that payment is due at the time of service unless other arrangements have been made. I agree that I am responsible for payment of all services rendered regardless of insurance coverage, if applicable. I understand that a 3% (36%APR) late fee may be added to any account balance over 60 days. If required, I also understand that a credit history inquiry may be made. There will be a \$30.00 charge for returned checks. Failure to keep agreed financial arrangements can be cause for the cancellation of any future appointments.

INITIAL: _____

Missed Appointments:

In order to serve you better and reduce the cost of dental care, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 48 hours notice for any cancelled appointment. If an appointment is missed or cancelled in less than 48 hours, we reserve the right to charge a broken appointment fee of \$50.00. We realize there are sometimes extenuating circumstances that will keep you from keeping a dental appointment. That is taken into consideration prior to charging the broken appointment fee.

INITIAL: _____

Patient Responsibilities:

Discourteous, rude or inappropriate behavior toward Dr. Welsh and/or staff can be cause for immediate termination of the relationship with this office.

INITIAL: _____

My signature below indicates that I have read and agree to the above written financial guidelines of Dr. Brad Welsh's office.

Signature of Responsible Party/Date: _____