Adel DENTAL GROUP

Child Patient Information

Child Name:_____ Nickname:_____
Date of Birth:_____ Grade: _____ Male ☐ Female ☐
Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Email:_____

Parent/Guardian Information

Parent/Guardian Name:_____ Relationship: _____
Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email:_____ Date of Birth:_____ Social Security Number:_____

Parent/Guardian Information

Parent/Guardian Name:_____ Relationship: _____
Address:_____ City:_____ State:_____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email:_____ Date of Birth:_____ Social Security Number:_____

With whom does the child reside? Mother ☐ Father ☐ Both ☐ Other ☐ _____

Person responsible for payment:_____

THE BIGGEST COMPLIMENT OUR PATIENTS CAN GIVE US IS THE REFERRAL OF THEIR FAMILY AND FRIENDS!

Whom may we thank for referring you?_____ If he/she a patient here? Yes ☐ No ☐

☐ Building sign ☐ Google ☐ Other
☐ Insurance company ☐ Yellow Pages _____
☐ Mailer/Advertisement ☐ Adel Dental Website _____

Previous Dentist:_____

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Information
Subscriber's Name:_____
Subscriber's Birthdate:_____
Subscriber's SSN or Carrier ID:_____
Employer Name:_____
Policy Number:_____
Insurance Company:_____
Insurance Address and Phone:_____
_____

Secondary Dental Insurance Information
Subscriber's Name:_____
Subscriber's Birthdate:_____
Subscriber's SSN or Carrier ID:_____
Employer Name:_____
Policy Number:_____
Insurance Company:_____
Insurance Address and Phone:_____
_____

I hereby authorize Dr. Anderson and/or his associates to perform any and all treatment for my child and consent to such methods, drugs and agents as may be indicated in connect with his/her dental care. This consent shall remain in effect until cancelled.
Please note:* *Payment is expected at time of services. If you provide proper insurance information, we will file your insurance as a courtesy. However, you are responsible for your account within the limits of our credit policy, regardless of insurance coverage.

Signature:_____

Adel DENTAL GROUP

Child Medical History

Patient Name:_____

Welcome to Adel Dental Group! We're excited to provide your child with the best possible care.

Please know that all medical history provided will be kept complete confidential.

What is the reason for your visit today?_____

Date of your child's last dental visit:_____

Is your child currently under a physician's care? Yes ☐ No ☐ _____

Is your child currently taking any medications, pills or drugs? Yes ☐ No ☐ List all medications: _____

_____

Are your child's immunizations current? Yes ☐ No ☐ _____

Is your child **allergic** to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Peanuts	☐ Corn	☐ Dairy	☐ Soy

Other allergies not listed? Yes ☐ No ☐ _____

Does your child have any allergic or adverse reactions to any medication or any other substance not listed above?

Yes ☐ No ☐ _____

Indicate which of the conditions your child currently has or has ever had:

☐ AIDS/HIV positive	☐ Allergies/Hives	☐ Anemia
☐ Asthma	☐ Behavioral/Learning Problems	☐ Bleeding Disorder
☐ Brain Injury/Concussions	☐ Cancer	☐ Cerebral Palsy
☐ Chicken Pox	☐ Congenital Heart Condition	☐ Diabetes
☐ Epilepsy/Seizures	☐ Handicap/Disability	☐ Hay Fever
☐ Hearing Problem	☐ Heart Condition	☐ Hepatitis A, B or C
☐ Kidney/Liver Problem	☐ Lung Problem	☐ Measles/Mumps
☐ Mononucleosis	☐ Nervous Disorder	☐ Psychiatric/Psychological
☐ Rheumatic/Scarlet Fever	☐ Sickle Cell Anemia	☐ Stomach Problems
☐ Tuberculosis	☐ Thyroid Problems	☐ Other_____

Additional conditions or information we should know about you:_____

To the best of my knowledge, the questions on the form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature:_____ Date:_____

Adel
DENTAL GROUP

PATIENT AUTHORIZATION FOR SERVICES

I hereby authorize doctor or staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of _____'s dental needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required in providing proper care. I agree to the use of anesthetic and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks, and that I can ask for complete recital of any possible complications.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I _____, acknowledge that I have been made aware of Adel Dental Group's Notice of Privacy Practices. This notice describes how the doctor may use or disclose my protected health information, certain restrictions on the use and disclosure of my health care information, and rights I may have regarding my protected health information.

I hereby grant access to my dental information to the following individual(s):

Person	Relationship
Person	Relationship

PATIENT PAYMENT FOR SERVICES AGREEMENT

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that I shall be responsible for any and all expenses incurred at this office, and I understand that payment is due at the time of services, unless other arrangements have been made, regardless if I have insurance. In the event payments are not received by the agreed upon dates, I understand a finance charge of 18% APR may be added to my account.

Adel Dental Group values the time for each appointment scheduled at our office. We appreciate a notification of 48 hours prior to any appointment cancellation. Please be advised, a fee may be applied for cancellations less than 24 hours prior to the scheduled appointment.

TO BE SIGNED AT YOUR VISIT

Signature:_____ Date:_____