Child Acquaintance Form

Patient/Parent or Guardian Information

Date _____ Home Phone (___) _____ Patient's Birthdate (m)___(d)___(y)___

Patient's Name _____ Address _____

City _____ State _____ Zip _____ Patient's Sex __ Male __Female Age _____

Patient's Social Sec. # _____

Father/Guardian's Name _____ Father/Guardian's Employer_____

Father/Guardian's Occupation _____ How long? _____

Father/Guardian's Business Phone (___)_____ Father/Guardian's Cell Phone (___) _____

Father/Guardian's Birthdate (m)____(d)___(y)____ Guardian's E-mail _____

Mother's Name _____ Mother's Employer _____

Mother's Occupation _____ How long? _____

Mother's Business Phone (___)_____ Mother's Cell Phone (___) _____

Mother's Birthdate (m)____(d)____(y)____

Whom may we thank for referring you? _____

Person to contact in emergency _____ Emergency Phone (___) _____

Person responsible for account _____ Relation to patient _____

Dental Insurance

Insured's Name _____ Relation to patient _____

Insured's Birthdate (m) _____ (d) _____ (y) _____ Social Sec. # _____

Address (if different from patient) _____ Phone (___) _____

City _____ State _____ Zip _____

Insured's Employer _____ Occupation _____ How Long? _____

Business Address _____ Business Phone (___) _____

Insurance Company _____

Group # _____ Identification # _____

Please let our receptionist copy your insurance card. Thank you.

Insurance Authorization

I hereby authorize the office of Brant P. Rouse, D.D.S., PLC to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to my dependents and me. I also authorize payment of healthcare benefits otherwise payable to me, directly to my dentist as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

Signature _____ **Date** _____

Acknowledgement of receipt of Notice of Privacy Practices

I _____ (print name) have received a copy of this office's Notice of Privacy Practices.

Signature _____ **Date** _____

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 ___ Communication barrier ___ Emergency situation ___ Other _____

Child Acquaintance Form

Child Dental History

Is this your child's first visit to the dentist? _____ If not, how long since the last dental visit? _____

Has your child had any problem with dental treatment in the past? _____

Has your child ever had dental x-rays? _____ Have any cavities been noted in the past? _____

Has your child had any trouble with the eruption or shedding of teeth? _____

Have any teeth (baby or permanent) been removed by extraction? _____

Have there been any injuries to teeth such as fractures, chips, etc.? _____

Has your child had any orthodontic treatment? _____

How many times are your child's teeth brushed each day? _____ When are they brushed? _____

Is fluoride toothpaste used? _____ What type of water does your child drink? __City __Well __Bottled __Rural

Does your child take fluoride supplements? _____ Does your child suck his/her thumb, fingers or pacifier? _____

Does your child eat sweets such as candy, soda pop, or chewing gum? _____ How often? _____

Health History

Name of Physician _____ Phone (___) _____

Is your child taking any medications at this time? If yes, please list: _____

Is your child allergic to penicillin, antibiotics, or other medications? If yes, please list: _____

Is our child allergic to anything else, such as certain foods? If yes, please explain: _____

Has your child ever had a serious illness? If yes, when: _____ Please describe: _____

Has your child ever been hospitalized? _____ Please describe: _____

Has your child had a history of any other illnesses? Please describe: _____

Has your child ever received a general anesthetic? _____ Ever had a blood transfusion? _____

Does your child have any inherited problems? _____ Speech difficulties? _____

Is your child physically, mentally, or emotionally impaired? _____

Does your child had a persistent cough greater than three weeks or cough that produces blood? _____

Does your child experience excessive bleeding when cut? _____

Is your child currently being treated for any illnesses? _____

Has the child had any history of, difficulty with, or diagnosis of any of the following:

___Anemia	___Arthritis	___Asthma	___Bladder
___Bleeding disorders	___Bones/Joints	___Cancer	___Cerebral Palsy
___Mouth Breather	___Chronic Sinusitis	___Diabetes	___Epilepsy / Seizures
___Fainting	___Growth problems	___Hearing	___Heart murmur
___Hepatitis	___HIV+/AIDS	___Immunizations	___Kidney
___Latex allergy	___Liver	___Stroke	___Measles
___Mononucleosis	___Mumps	___Pregnancy (teens)	___Rheumatic fever
___Heart attack	___Sickle cell	___Thyroid	___Tobacco/Drug use
___Tuberculosis	___Venereal disease	___Other _____	

I certify that I have read and understand the above and that my answers are complete and accurate. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I understand it is my responsibility to inform this office of any changes in medical status.

Signature_____ **Date** _____ **Relation to child** _____

Doctor	Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____
Review	Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____

Child Acquaintance Form

Brant P. Rouse D.D.S Family & Restorative Dentistry
Office Policies

Appointments

- Appointments that are not kept, or that are canceled without 24 hours notice, are a loss for everyone. Please inform us at least 24 hours in advance of any appointments that you will be unable to keep. *A fee may be charged for missed appointments.*

Payment

It is our mission to provide the best possible dental care for our patients. In an effort to keep our fees affordable, we have adopted the following policies:

- *Payment is expected at the time of services.* Financial arrangements must be made in advance of treatment. Patients are responsible for payment for all dental services rendered. Patients who carry dental insurance/supplement understand that we will file your insurance forms or assist in collections from your insurance, but ultimately the patient is responsible for treatment rendered. We will credit any such collections to the patient's account. However, this office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions that the office may not be aware of. The office staff will estimate insurance coverage to the best of their ability, but the patient agrees this is an estimate only, not a guarantee of coverage.

- For that portion of costs not covered by insurance, or for those without dental insurance, we offer several payment options:

  - Cash or personal check
  - Credit card – we accept MasterCard and Visa
  - *CareCredit Payment Plans – Our office offers third party payment plans through CareCredit with low, fixed rates. The rate depends on the term applied for and your credit standing. Interest-free terms are also available. You can apply in our office or online at www.carecredit.com

I have read and understand the office policies of Dr. Brant P. Rouse, D.D.S. I agree to abide by these policies and that I am responsible for payment of my account.

Signature _____ **Date** _____

Parent/Guardian if patient is a minor _____