PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Name: _____ MI___ _____ M___F___

Address: _____

City, State, Zip: _____

Home Phone: (_____) _____ Cell: (_____) _____

Social Security No: _____ Date of Birth: _____

ARE THERE ANY SIBLINGS THAT COME HERE: _____

Referred by: _____

Mother/Legal Guardian's Name: _____
Have you ever been a patient here: Yes ___ No ___
Social Security No: _____ Date of Birth: _____

Address: _____

Home Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____

Fathers/Legal Guardian's Name: _____
Have you ever been a patient here: Yes ___ No ___
Social Security No: _____ Date of Birth: _____

Home Phone: (_____) _____

Employer: _____ Work Phone: (_____) _____

DENTAL INSURANCE INFORMATION:

Primary Insurance: _____
Subscriber Name: _____ Date of Birth: _____
Policy No: _____ Group No: _____
Claims Address: _____
Secondary Insurance: _____
Subscriber Name: _____
Policy No: _____ Group No: _____
Claims Address: _____

EMERGENCY CONTACT: _____
Phone: _____

I authorize release of any information concerning r my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I recognize that I am responsible to pay any charges not covered by my insurance.

Signature of parent or guardian of minor _____ Date _____

Dental & Medical History Information

Dental History

Patient Name _____ Reason for today's visit _____
Previous Dentist _____ City/State _____
Date of last dental visit: _____ Date of last dental x-rays: _____
Times a day child brushes? ____ __ Flosses? ___ ___ Drinks fluoridated water? _____
Please check all that apply:

- ☐ Bad breath
- ☐ Mouth breathing
- ☐ Sensitivity
- ☐ Brushing pain
- ☐ Orthodontic treatment
- ☐ Ringing in ears
- ☐ Chipped/ Broken tooth
- ☐ Loose teeth
- ☐ Stained teeth
- ☐ Sores in mouth
- ☐ Broken/loose fillings
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Chew on one side of mouth
- ☐ Tobacco Use
- ☐ Clicking or popping jaw
- ☐ Grinding teeth
- ☐ Swollen/tender gums
- ☐ Locking jaw
- ☐ Lip biting/sucking

Medical History

Physician's Name _____ City/Phone _____
Please check all that apply:

- ☐ ADD/ADHD
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Autism
- ☐ Birth Defects
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer: Type_____
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Congenital Heart Defects
- ☐ Diabetes
- ☐ Down syndrome
- ☐ Epilepsy
- ☐ Fainting
- ☐ Heart Murmur: PreMed? _____
- ☐ Hearing Impairment
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Psychiatric Problems
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Sensory Disorder
- ☐ Surgeries/Operation
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Visual Impairment
- ☐ Other_____

Please list any medications that your child is taking: _____
_____

Allergies

Please check all that apply:

- ☐ Amoxicillin
- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Food Allergies
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other___ ___

I certify that to the best of my knowledge the questions on this form have been accurately answered. I will not hold Dr. Crisp or any staff member responsible for any action they take or do not take because of errors that I have made in completion of this form. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform this dental office of any changes in my child's medical history.

I authorize the staff to perform any necessary services needed during diagnosis and treatment of my child.

Signature _____ **Date** _____

Tim F.Crisp D.M.D.
11 Canary Lane
Winchester, KY 40391
859-744-7031

Notice of Privacy Practices
Consent & Authorization

Tim Crisp D.M.D. reserves the right to speak with a patient's primary care physician at any time to discuss the health and well being of a mutual patient.

We will continue to phone in prescriptions at the parent's request for the patient at the pharmacy of their choice. Signing this consent form gives the office of Dr. Tim Crisp permission.

Patient medical records will NOT be released without prior authorization from the patient's parent or legal guardian. We will accept authorization by mail, fax or from the new dental office treating the patient.

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I _____ am the parent/legal guardian of _____
(Parent or Legal Guardian) **(Patient's Name)**

I give my permission to be contacted by the following manner:

- ☐ Home Telephone
- ☐ Work Telephone
- ☐ OK to leave a detailed message?
- ☐ OK to mail to my home address?

Other OR Restrictions SUCH AS: **Do not wish to have primary care physician and/or pharmacy contacted.**

_____

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Disclosures that can be made without consent of authorization: As required during an investigation by law enforcement agencies; As required by military command authorities for their medical records; In response to a legal proceeding; To a coroner or medical examiner for identification of a body; Other covered entities' and providers' payment activities; Uses and disclosure required by law; Uses and disclosures in domestic violence or neglect situations.

I UNDERSTAND THE POLICY & PROCEDURES OF THE OFFICE OF TIM CRISP D.M.D.

Patient's Name: _____

Signed: _____ **Date:** _____
(Parent/Legal Guardian)

Filename: Privacy & Policy/Consent/Authorization

Tim F. Crisp Pediatric Dentistry

11 Canary Lane

Winchester KY, 40391

In the event that I am ever unable to bring my child to his/her appointment the individuals listed below have my permission to bring them and be treated in my absence.

Patient Name: _____

Parent/Guardian:_____

Name	Relationship	Phone Number

Parent/Guardian Signature: _____ Date: _____

FINANCIAL AGREEMENT
Dr. Tim F. Crisp

Patient name:_____

Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining health service. If your insurance company rejects a claim and refuses to pay for a service, it is not a reflection of how important the service is.

Please note our agreement is with you, **NOT** your insurance company. If your insurance company refuses to pay or pays less than estimated, you must remember that dental insurance is designed to offset the costs of your dental treatment. You are responsible for the cost of your treatment and any insurance reimbursement conflicts. Our office staff will help you to the best of our ability to obtain your maximum benefits. *We strongly advise you, as our patient, to familiarize yourself with your dental coverage and your benefits.* If a claim is not paid, you will be responsible for the balance.

We are providing the following payment options, being sensitive to the fact that different people have different needs in fulfilling their financial obligations:

1. We accept Check, Cash, Money Order, Visa, MasterCard, or Discover.
2. We offer interest free extended payment plans through Care Credit.

Please note: Our office has a 24 hour cancellation policy. Your appointment is time reserved especially for you as our patient to provide for your dental needs. We strive to provide you with a courtesy reminder call, however it is ultimately your responsibility to remember your dental appointment. Please note that there is a **$15.00** fee for appointments cancelled less than a 24 hour notice or broken appointments.

Parent/Guardian Signature:_____

Date:_____