Vann Pediatric Dental

Patient Information

Date_____

Social Security Number_____

Child's Full Name_____

Preferred Name_____

Address_____

_____

City_____

State_____ Zip_____

Sex ☐M ☐F Age_____

Birthdate_____

Contact Numbers: Please List as many as possible.

Best time/number to call:_____

Home Phone_____ Cell Phone_____

Work Phone_____ Other Phone_____

Other Phone_____ E-Mail_____

What is your child's favorite hobby, character, sport, animal, etc?_____

_____

How did you find out about us?_____

_____

Parental Permission

The following people have my permission to bring and/or pick up my child to/from his/her dental appointments and also have a thorough understanding of my child's medical history so as to answer any questions Dr. Vann & Associates or any of their staff may have. The following people have the authority to make decisions relating to my child's dental care. Please list names along with relation to patient.

_____

_____

_____

_____

_____

_____

Insurance Information

Subscriber's Name_____

Relationship to Patient_____

Subscriber's DOB_____

Subscriber's SSN/ID_____

Subscriber's Employer_____

Subscriber's Address_____

Insurance Company Name_____

Group Number_____

Is patient covered by an additional insurance? ☐ Yes ☐ No

If additional coverage please list below:

Subscriber's Name_____

Relationship to Patient_____

Subscriber's DOB_____

Subscriber's SSN/ID_____

Subscriber's Employer_____

Subscriber's Address_____

Insurance Company Name_____

Group Number_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage and assign directly to Dr. Michael Vann & Associates, Inc/Vann Pediatric Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature_____

Relationship_____

Dental History

Date of last dental visit_____ Dentist Name_____

Date of last X-Rays_____

Has child complained of any dental pain?_____

Has there been any trauma to the mouth, teeth, head?_____

Any past or present mouth habits: thumb/digit sucking, bottle at night, pacifier, etc?_____

Any unusual speech patterns?_____

Any past/present orthodontic treatment?_____

Any TMJ/TMD symptoms?_____

Does your child brush their teeth, how often?_____

Do you assist child with brushing, how often?_____

Is dental floss used, how often?_____

Is fluoride taken in any form?_____

Does your child eat frequent between meal snacks or drinks?_____

If yes, what are they?_____

How do you expect your child to behave on this visit?_____

_____

How have they reacted at past medical/dental experiences?_____

Do you desire complete dental services for the child? ☐Yes ☐No_

Privacy Practices

I hereby acknowledge that I have reviewed Dr. Vann & Associates, Inc's notice of Privacy Practices.

Signature of Parent/Guardian_____

Date_____

Consent: Because the patient is a minor, it is necessary for us to have consent of the parent or legal guardian prior to rendering dental treatment. Your signature below authorizes Dr. Vann & Associates, Inc./Vann Pediatric Dental to perform any dental treatment that your child may need. If the patient is in the custody of a non-parent, we must have a copy of the guardianship agreement or court order before the patient is seen by Dr. Vann & Associates, Inc./Vann Pediatric Dental

Agreement To Pay: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs is such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any state.

Signature_____ Date_____

Medical History

Name Of Pediatrician_____ Phone #_____

Date of last visit_____

Please circle any of the following that your child currently has or has had in the past:

Allergic Reactions	Heart Problems	Liver Problem
Sickle Cell Disorder	Kidney Problem	Heart Murmur
Breathing Problems	Bleeding Disorder	Infectious Disease
Cerebral Palsy	Chicken Pox Mumps	Asthma
Congenital Disorder	Hearing	Easily Bruised
Developmental Delays	Epilepsy/Seizures	Ulcers
Cold Sore/Fever Blister	Diabetes	Hives/Rash
Head Injuries	Fainting	Autism
Hemophilia/VWD	Anemia	Vision
Hepatitis	High Blood Pressure	Jaundice
Arthritis/Gout	Frequent Infections	Lung Problems
Cancer/Leukemia	Transfusions	Tuberculosis
Venereal Disease	Pregnancy	Mental Disorders
Stomach/Intestine Disorder	Sinus Problems	Artificial Joints
Rheumatic Fever/Scarlet	Frequent Ear Problems	Chemo/Radiation

If you circled any of the above, please explain_____

_____

_____

Is the patient taking any medications_____

_____

Does the patient have any allergies _____

_____

Has your child ever had any complications following dental treatments?

☐Yes ☐No If yes, please explain_____

_____

Has your child been admitted to a hospital or needed emergency care during the past? ☐Yes ☐No If yes, please explain_____

_____

Is your child now under the care of a physician?_____

Does your child have any health problems that need further clarification?

☐Yes ☐No If yes, please explain_____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child ever has any change in health, I will inform the doctor at the next appointment without fail.