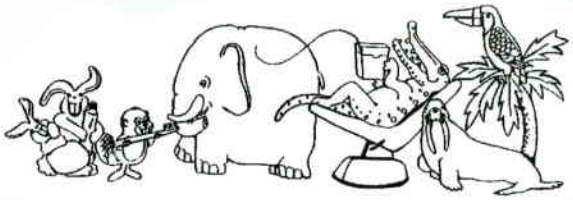
NEW PATIENT HEALTH HISTORY AND FAMILY INFORMATION



North Penn Pediatric Dental Associates, LLC

SPECIALISTS IN PEDIATRIC DENTISTRY & ORTHODONTICS
2100 N. Broad Street, Lansdale, PA 19446
Tel (215) 855-4092 | Fax (215) 855-2061 | www.nppda.com

Welcome!

We welcome you and your family to our pediatric/orthodontic dental office. Our staff is committed to making each visit pleasant and informative while maintaining the highest quality dental care.

Thank you for completing this form. It helps to ensure that we provide the best dental care possible for your child. If at any time you or your child have any questions or concerns, please ask us. We enjoy educating our patients and stressing preventive care!

About Your Child

CHILD'S FULL NAME _____ NICKNAME _____

CHILD'S HOME ADDRESS _____

MALE/FEMALE _____ BIRTH DATE _____ TELEPHONE NO. _____

SPECIAL INTERESTS (HOBBIES, SPORTS, ETC. PLEASE LIST ALL SPORTS IN WHICH YOUR CHILD PARTICIPATES.) _____

REFERRED BY _____

About Mom

NAME _____ SOCIAL SECURITY NO. _____

BIRTH DATE _____ MARITAL STATUS _____ ADDRESS (IF DIFFERENT FROM CHILD) _____

HOME PHONE NO. _____ WORK PHONE NO. _____ CELL PHONE NO. _____

FAX NO. _____ EMAIL ADDRESS _____

EMPLOYER _____ EMPLOYER'S ADDRESS _____

DENTAL INSURANCE CO. _____ GROUP NO. _____

DENTAL INSURANCE CO. ADDRESS _____ DENTAL INSURANCE CO. PHONE NO. _____

MEDICAL INSURANCE CO. _____ GROUP NO. _____

MEDICAL INSURANCE CO. ADDRESS _____ MEDICAL INSURANCE CO. PHONE NO. _____

NEW PATIENT HEALTH HISTORY AND FAMILY INFORMATION

About Dad

NAME _____ SOCIAL SECURITY NO. _____

BIRTH DATE _____ MARITAL STATUS _____ ADDRESS (IF DIFFERENT FROM CHILD) _____

HOME PHONE NO. _____ WORK PHONE NO. _____ CELL PHONE NO. _____

FAX NO. _____ EMAIL ADDRESS _____

EMPLOYER _____ EMPLOYER'S ADDRESS _____

DENTAL INSURANCE CO. _____ GROUP NO. _____

DENTAL INSURANCE CO. ADDRESS _____ DENTAL INSURANCE CO. PHONE NO. _____

MEDICAL INSURANCE CO. _____ GROUP NO. _____

MEDICAL INSURANCE CO. ADDRESS _____ MEDICAL INSURANCE CO. PHONE NO. _____

Dental & Medical History

Date of child's last dental visit: _____

FOR WHAT PURPOSE? _____

Were dental x-rays taken in the last six months? ☐ YES ☐ NO

Is your child currently experiencing any dental pain or problem? ☐ YES ☐ NO

IF SO, PLEASE EXPLAIN _____

Does your child brush daily? ☐ YES ☐ NO

Floss? ☐ YES ☐ NO

Has your child experienced injuries to the head, teeth or mouth? ☐ YES ☐ NO

Thumb or finger sucking, nail biting, mouth breathing? ☐ YES ☐ NO

Does your child eat a balanced diet? ☐ YES ☐ NO

Has your child stopped taking a bedtime bottle? ☐ YES ☐ NO

IF SO, AT WHAT AGE? _____

Our office is committed to meeting or exceeding the standards for infection control mandated by OSHA, the CDC and the ADA.

Does your child drink from a bottle or sippy cup during the day? ☐ YES ☐ NO

Pacifier? ☐ YES ☐ NO

Does your child grind her/his teeth? ☐ YES ☐ NO

Fluoride supplements? ☐ YES ☐ NO

Had any orthodontic treatment? ☐ YES ☐ NO

NAME OF CHILD'S **PEDIATRICIAN** _____

ADDRESS _____

PHONE NUMBER _____

NAME OF ANY **OTHER PHYSICIAN** _____

ADDRESS _____

PHONE NUMBER _____

Is your child currently under the care of a physician? ☐ YES ☐ NO

IF YES, FOR WHAT PURPOSE? _____

Does your child have any allergies? ☐ YES ☐ NO

IF YES, PLEASE LIST _____

(continued on page 3)

Dental & Medical History, continued

Is your child or adolescent recovering from the disease of chemical dependency? ☐ YES ☐ NO

Is your child taking any medications or drugs? ☐ YES ☐ NO

IF SO, PLEASE LIST (NAME, DOSE, FREQUENCY) _____

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING:

Anemia ☐ YES ☐ NO
Apnea or snoring ☐ YES ☐ NO
Asthma ☐ YES ☐ NO
Autism ☐ YES ☐ NO
Excessive bleeding ☐ YES ☐ NO
Blood disorder ☐ YES ☐ NO
Bone or joint problems ☐ YES ☐ NO
Cancer ☐ YES ☐ NO
Cerebral Palsy ☐ YES ☐ NO
Chemotherapy ☐ YES ☐ NO
Chronic sinusitis ☐ YES ☐ NO
Cleft lip or palate ☐ YES ☐ NO
Congenital anomalies ☐ YES ☐ NO
Convulsions or seizures ☐ YES ☐ NO
Cystic fibrosis ☐ YES ☐ NO
Delayed Development ☐ YES ☐ NO
Dermatologic or skin problems ☐ YES ☐ NO
Diabetes ☐ YES ☐ NO
Ear infections ☐ YES ☐ NO
Eating disorder ☐ YES ☐ NO
Emotional problems ☐ YES ☐ NO
Eye problems or visual impairment ☐ YES ☐ NO
Excessive gagging ☐ YES ☐ NO
Fainting ☐ YES ☐ NO
Growth problems ☐ YES ☐ NO
Gastric Reflux ☐ YES ☐ NO
Hearing impairment ☐ YES ☐ NO
Heart problems ☐ YES ☐ NO
Hemophilia ☐ YES ☐ NO
Hepatitis ☐ YES ☐ NO
High blood pressure ☐ YES ☐ NO
HIV or AIDS ☐ YES ☐ NO
Hyperactivity ☐ YES ☐ NO
Immune disorder ☐ YES ☐ NO
Intestinal problems ☐ YES ☐ NO
Kidney problems ☐ YES ☐ NO
Lesions in or around the mouth ☐ YES ☐ NO
Liver disease ☐ YES ☐ NO
Mental/Intellectual Deficiency ☐ YES ☐ NO
Radiation therapy ☐ YES ☐ NO
Respiratory problems ☐ YES ☐ NO
Rheumatic Fever ☐ YES ☐ NO
Rheumatic heart disease ☐ YES ☐ NO
Shunts ☐ YES ☐ NO
Sickle cell disease ☐ YES ☐ NO
TMJ problems ☐ YES ☐ NO
Tuberculosis ☐ YES ☐ NO
Chronic adenoid or tonsil infections ☐ YES ☐ NO
Venereal Disease ☐ YES ☐ NO
Any Syndrome ☐ YES ☐ NO

IF SO, PLEASE SPECIFY _____

Any operations ☐ YES ☐ NO

IF SO, PLEASE SPECIFY _____

Any health condition which necessitates antibiotics prior to dental treatment? ☐ YES ☐ NO

Any complications during the pregnancy or birth? ☐ YES ☐ NO

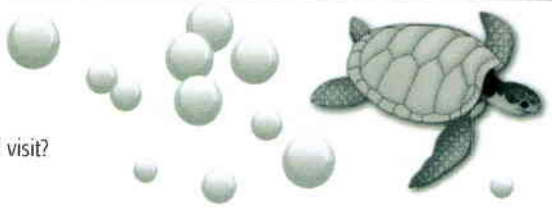
Was your child born prematurely? ☐ YES ☐ NO

Is there any family history of serious medical conditions? ☐ YES ☐ NO

Are there any other medical conditions of which we should be aware? ☐ YES ☐ NO

IF SO, PLEASE EXPLAIN _____

Dental Updates



Have there been any changes in your child's medical condition since the last dental visit?

1. ☐ YES ☐ NO DATE: _____ SIGNATURE: _____

COMMENTS: _____

2. ☐ YES ☐ NO DATE: _____ SIGNATURE: _____

COMMENTS: _____

3. ☐ YES ☐ NO DATE: _____ SIGNATURE: _____

COMMENTS: _____

4. ☐ YES ☐ NO DATE: _____ SIGNATURE: _____

COMMENTS: _____

5. ☐ YES ☐ NO DATE: _____ SIGNATURE: _____

COMMENTS: _____

6. ☐ YES ☐ NO DATE: _____ SIGNATURE: _____

COMMENTS: _____

7. ☐ YES ☐ NO DATE: _____ SIGNATURE: _____

COMMENTS: _____

8. ☐ YES ☐ NO DATE: _____ SIGNATURE: _____

COMMENTS: _____

Emergency Contact

In the event of an emergency, whom should we contact (other than the child's parent)?

NAME _____

TELEPHONE NO. _____

RELATIONSHIP TO CHILD _____

▶ _____

SIGNATURE OF PARENT OR GUARDIAN **DATE**

Financial Responsibility

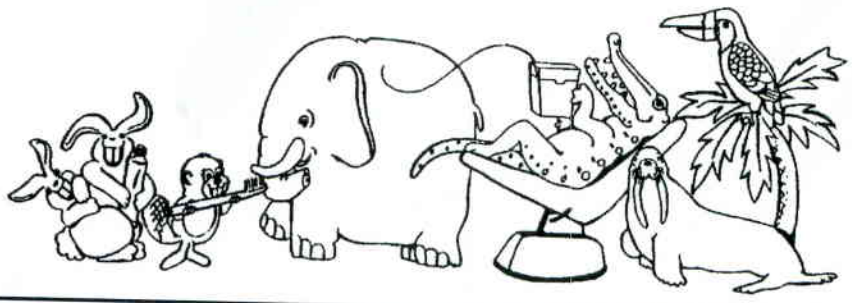
I hereby agree to be financially responsible for all balances due for services rendered, including charges unpaid by any insurance carriers. I agree, that if the balances are not paid within 30 days of billing, I am liable for that balance and any service or late fees charged up to 1½% per month.

PARENT/GUARDIAN/FINANCIALLY RESPONSIBLE PARTY _____

DATE _____

▶ _____

SIGNATURE OF DOCTOR **DATE**



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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected dental/health information will be used by this practice, known as *North Penn Pediatric Associates,* or disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

You may request a restriction on the use or disclosure of your protected health information. If you should wish to restrict your disclosure, you should make the request in writing.

This practice, however may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restriction will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

NAME OF PATIENT (PRINT CLEARLY) _____ DATE _____

SIGNATURE OF PATIENT REPRESENTATIVE _____ RELATIONSHIP TO PATIENT _____

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NORTH PENN PEDIATRIC DENTAL ASSOCIATES

Missed Appointment Policy

We want to thank you for choosing our practice to provide dental care for your children. In order to provide you and our other families with the best care we ask that you follow our guidelines regarding cancelled/rescheduled appointments. Keep in mind that we have reserved an appointment time especially for you.

Missing an appointment without notifying the office creates a missed opportunity for us to help another patient. We ask that you make every effort to keep your scheduled appointment and to arrive on time.

We do understand there may be circumstances when you will be unable to keep your appointment due to serious emergencies or serious illness. We ask that you give us 24 hours' notice of cancellation/reschedule when possible. This will enable us to offer your appointment slot to another patient. It is our policy to charge for a missed appointment that is not cancelled or rescheduled in a timely manner. Exceptions will be made for serious emergencies and serious illness.

A charge of $25.00 will be made to patients who do not show up for their appointment and do not call to advise the office prior to their appointment time. This charge will be billed to the parent or guardian and is their responsibility.

Thank you,

North Penn Pediatric Dental Associates, LLC

I have read and understand this policy_____

Date_____