OXFORD DENTAL SPECIALISTS, PLLC

THE FOLLOWING INFORMATION & HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT & UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING THIS INFORMATION IN FULL.

Patient's Name_____ **Nickname**_____

Age_____ **Sex**_____ **Race**_____ **DOB**_____ **SS#**_____

Patient's Address_____

City_____ **State**_____ **Zip**_____

Home Phone_____ **Whom Does The Patient Live With**_____

Father's Name_____ **DOB**_____ **SS#**_____

Father's Address (if different)_____

City_____ **State**_____ **Zip**_____

Employer_____ **E-Mail**_____

Work Phone_____ **Cell Phone**_____

Mother's Name_____ **DOB**_____ **SS#**_____

Mother's Address (if different)_____

City_____ **State**_____ **Zip**_____

Employer_____ **E-Mail**_____

Work Phone_____ **Cell Phone**_____

Dental Ins? YES_____ **NO**_____ **Ins Company**_____

Mailing Address_____

Policy #_____ **Group#**_____ **Plan Under? Mom**_____ **Dad**____

Oxford Dental Specialists, PLLC

2408 S. Lamar Blvd Ste 1 | Oxford, MS 38655 | 662-513-4188

Patient Dental History

Please answer the following questions:

Is this your child's first visit to the dentist? Yes No

If no, when was the last visit?

Has your child had a negative experience with previous dental visits? Yes No

If yes, please explain?

Does your child have a toothache? Yes No If yes?

Has your child ever had dental xrays? Yes No

If yes, when? What dental office/dentist?

Has your child ever experienced headaches, pain, popping or clicking of the jaws? Yes No If yes?

Are you pleased with the appearance of your child's smile? Yes No If no?

Was your child referred by another dentist? Yes No If yes, who?

Does your child still use a bottle, sippy cup or is nursing? Yes No If yes?

Other comments?

Please answer the following questions:

Does your child have or has he/she had any of the following?			Yes	No
☐ Thumb Sucking	How long?		Still active?	Yes No
☐ Finger Habit	How long?		Still active?	Yes No
☐ Pacifier	How long?		Still active?	Yes No

Reason for visit:

☐ Cosmetic	☐ Habit	☐ Facial Swelling
☐ Pain	☐ Grinding Teeth	☐ Routine Checkup/Cleaning
☐ Emergency	☐ First Visit, No Problem	☐ Physical or Mental Handicap
☐ Dental Decay	☐ Other Please specify:	

Preventive

How often does your child brush?

Is tooth brushing supervised? Yes No

Is dental floss used? Yes No

Does your child's gums bleed while brushing or flossing? Yes No

Does your child receive:

- ☐ Fluoridated water (city or county) How Much?
- ☐ Bottled water How Much?
- ☐ Well water How Much?
- ☐ Fluoride in vitamins How Much?
- ☐ Fluoride in tablets/drops How Much?

Patient Medical History

Is your child presently under the care of a Pediatrician or Family Physician for any medical reason?

Yes No If Yes, explain:

Physician's Name: Phone Number:

Is your child in good health? Yes No If No, explain:

Does your child have any allergies?

☐ No Known Allergies ☐ Penicillin or other Antibiotics ☐ Codine ☐ Asprin ☐ Latex

☐ Iodine ☐ Sulfa Drugs ☐ Red Dye ☐ Food Allergies ☐ Other:

Is your child taking any medications at this time? Yes No If Yes, list:

Has your child ever been hospitalized or treated in an emergency room for trauma? Yes No

If Yes, when and for what reason:

Does your child have, or has he/she had, and emotional, mental or nervous disorders? Yes No

If yes, explain?

Has your child's tonsils and/or adenoids been removed? Yes No

Has your child ever had general anesthesia? Yes No What is your childs approximate weight?

Please indicate if your child has or has had any of the following:

☐ Vision Disorder	☐ Positive for HIV	☐ Cleft Palate
☐ Pulmonary Disorder	☐ Diabetes	☐ Asthma
☐ Radiation Treatment	☐ Epilepsy, Seizures	☐ Liver Problems or Hepatitis
☐ Tobacco Use	☐ Bleeding Disorder	☐ Malignancies or Leukemia
☐ Rheumatic Fever	☐ Tuberculosis	☐ Speech Problem
☐ Bone Disorder	☐ Endocrine Disorder	☐ Sickle Cell Anemia
☐ Cerebral Palsey	☐ Autism	☐ ADD/ADHD
☐ Mental Disorder	☐ Heart Ailment or Murmur	Type, if known:

Is child under the care of a cardiologist or special physician for the problem? Yes No

Physician: Office Phone:

Comment on any other problems that were checked above:

DO YOU CONSIDER YOUR CHILD TO BE:

- Advanced in the learning process.
- Progressing normally.
- A slow learner

Authorization, Release, & Agreement to Pay for Servcies Rendered

I give my concent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for (child's name). I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatment, x-rays and examinations) before that treatment is performed.

☐ I acknowledge. Date: Time:

THE CHILDREN'S DENTAL CENTER

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

Section A: Must be completed for all authorizations.

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that *if* the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient name:_____ ID Number: _____

Persons/Organizations authorized to release the information: The Children's Dental Center
Persons/Organizations authorized to receive the information: Advertising and Marketing
Specific description of information (including date(s)): Pictures of my child

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire when I notify The Children's Dental Center of my wish to terminate this authorization Initials:_____

2. I understand that I may revoke this authorization at any time by notifying The Children's Dental Center in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions The Children's Dental Center took in reliance upon my authorization before it received my revocation.

   Initials:_____

   You may revoke this authorization by signing a Revocation of Authorization form and returning it to The Children's Dental Center. To request a Revocation of Authorization form, you may contact us at The Children's Dental Center at (662) 513-4188.

3. The Children's Dental Center will not condition your treatment or payment for your health care services on your completing and signing this authorization. Initials: _____

Section B: Must be completed when The Children's Dental Center requests the authorization for its own use or for another covered entity to disclose information to The Children's Dental Center for treatment, payment or health care operations purposes.

To be completed by The Children's Dental Center:

1. The purpose of the use or disclosure is: Advertising and Marketing purposes
2. The Children's Dental Center will not receive direct or indirect compensation in exchange for using or disclosing the information listed above.

NOTICE TO PATIENT: You or your representative may inspect and/or copy the health information in accordance with The Children's Dental Center's policies.

Section C: Must be completed for all authorizations.

Patient Name:_____ **Patient Social Security Number:**_____
(Please Print)

_____ _____
Signature of patient or patient's representative **Date**

Printed name of patient's representative:_____
Relationship to patient:_____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

7/02

{North Mississippi Dental Specialists, PLLC}

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For 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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

The Children's DENTAL CENTER
C. Hayden Perkins, DMD
Dental Care for infants, children, adolescents & teenagers
Diplomate, American Board of Pediatric Dentistry

PARENTS PLEASE READ

1. Please bring your insurance card with you to your appointment. If we do not have the proper information and cannot verify coverage, you will be considered **self-pay**.

2. If you have private dental insurance, which is all dental insurances **except** CHIPS or Medicaid, it is very important that you read over your policy and familiarize yourself with what your insurance **WILL** or **WILL NOT** pay on the procedures your child will have done the day of his/her appointment. We file your insurance as a **COURTESY TO YOU**. We also verify eligibility and get a general breakdown of benefits and, if treatment is needed, we provide you with a close estimate of what your insurance will pay and how much you will be responsible for paying. However it is **your** responsibility to know the details of your dental insurance benefits.

3. We are **NOT** in network with any dental insurance plan. This means that your insurance company reserves the right **NOT** to pay the full amount of preventive services covered at 100%.

4. Please notify us by phone or at the front window if there are any changes to the following:
    a. Insurance
    b. Address
    c. Phone Number
    d. Names on the account

5. If you have an **E-MAIL** address, please put it on your new patient paper work or on the sign-in sheet at the front window.

2408 S. Lamar Blvd., Ste. 1, Oxford, MS 38655
Tel: 662-513-4188 • Fax: 662-513-4180