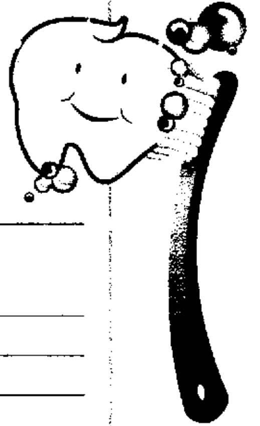
thank you for selecting us.

Patient ID # ____________________

Today's Date ____________________

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.



Your Child

Child's Name ____________________ Sex ______ Age ______

Nickname ______________ SS#/SIN ______________ Birthdate ______________

School ____________________ Grade ______________

Child's Home Address ____________________

City ______________ State/Prov. ______ Zip/P.C. ______ Phone ______________

Responsible Party

Name ____________________ Relationship ______________

Address ____________________ Email ______________

City ______________ State/Prov. ______ Zip/P.C. ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

SS#/SIN ______________ DL # ______________

Who is Responsible for Making Appointments? ____________________

Parent or Guardian Information ☐ Mother ☐ Stepmother ☐ Guardian

Name ____________________ Email ______________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Employer ______________ Occupation ______________

SS#/SIN ______________ DL # ______________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent or Guardian Information ☐ Father ☐ Stepfather ☐ Guardian

Name ____________________ Email ______________

Home Phone ______________ Cell Phone ______________ Work ______________

Employer ______________ Occupation ______________

SS#/SIN ______________ DL # ______________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Insurance

Insured's Name ____________________ Relationship ______________

Birthdate ______________ SS#/SIN ______________

Employer ______________ Date Employed ______________ Occupation ______________

Insurance Co. ______________ Group # ______________ Employee # ______________

Ins. Co. Address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

Deductible ______ Copay ______ Amount already used ______ Max. annual benefit ______

Additional Insurance

Insured's Name ____________________ Relationship ______________

Birthdate ______________ SS#/SIN ______________

Employer ______________ Date Employed ______________ Occupation ______________

Insurance Co. ______________ Group # ______________ Employee # ______________

Ins. Co. Address ______________ City ______________ State/Prov. ______ Zip/P.C. ______

Deductible ______ Copay ______ Amount already used ______ Max. annual benefit ______

Over Please

Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient ID # ______

How often does your child brush? ______

How often does your child floss? ______

Is your child's water fluoridated? ☐ Yes ☐ No

Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of Last Dental Visit ______

Previous Dentist ______

Address ______

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Has your child ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Has your child ever had any of the following:

Asthma	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐ Yes	☐ No

Child's Physician ______ Phone # ______

Address ______

Previous Hospitalizations/Surgeries/Serious Illnesses ______ When? ______

Is your child currently taking any medications? ☐ Yes ☐ No (if yes, please list) ______

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) ______

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? ______

Please explain any medical problems that your child has: ______

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent/Guardian if minor) ______ Date ______

Dentist's Review: ______

Signature of Dentist ______ Date ______

GREENLEAF DENTALCARE

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided:

Examinations X Preventive Services (including x-rays) X Restorations X Patient Initials: _________

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock. Patient Initials: _________

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary. Patient Initials: _________

4. If applicable, I give permission for this the dental office to bill my dental insurance provider for the treatment provided. Patient Initials: _________

______________________________ ______________________________

Patient Signature Date

Print Name: ______________________

Consent For Use and Disclosure of Health Information

SECTION A: PATIENT GIVING CONSENT

Name:____

Date Of Birth:___________________________________

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations. In addition, the uses and disclosures we *may* make of your protected health information, and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices. Changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: CATHERINE T. HARDY (OFFICE MANAGER) **TELEPHONE:** 978-374-7942

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE:

I have had full opportunity to read and/or consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:____________________________________ Date:_______________________

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:____________________________ Relationship:__________________

REVOCATION:

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or continue to treat me after I have revoked my Consent.

Signature:____________________________________ Date:_______________________

PAYMENT POLICY

1. Please keep in mind you are responsible for your total obligation should your insurance benefits result in less that anticipated.

2. Your portion is payable at each visit.

3. As a courtesy, we will fill out your claim forms with you, answer any questions we can and try to help you get the most benefit out of your particular policy.

4. We accept cash, checks, mastercard and visa.

5. Financing is available through CARE CREDIT, there are no in-office payment plans.

6. Due to unforeseen circumstances in dentistry, original treatment plans are subject to change.

7. If you miss and/or same day cancel three (3) appointments you will be dismissed from the practice.

Thank you for your cooperation.

____

Signature **Date**