Welcome

Patient ID # _____ Today's Date _____

to our practice! 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 _____ Nickname _____ Sex _____
Birthdate _____ Age _____ SS #/SIN _____ Phone _____
School _____ Grade _____
Child's Home Address _____ City _____ State _____ Zip _____

Responsible Party

Name _____ Relationship _____
Address _____ City _____ State _____ Zip _____
E-Mail _____ SS #/SIN _____ DL # _____

Who is responsible for making appointments?

Name _____ Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____ Best time to call _____ Time _____ Days _____

Mother ☐ Stepmother ☐ Guardian

Name _____ Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____ E-Mail _____
Employer _____ Occupation _____
SS #/SIN _____ DL # _____

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

Father ☐ Stepfather ☐ Guardian

Name _____ Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____ E-Mail _____
Employer _____ Occupation _____
SS #/SIN _____ DL # _____

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

Primary Insurance

Insured's Name _____ Relationship _____
Birthdate _____ SS #/SIN _____ Employer _____ Date Employed _____
Occupation _____
Insurance Company _____ Group # _____ Employee # _____
Ins. Co. address _____
City _____ State _____ Zip _____
Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Additional Insurance

Insured's Name _____ Relationship _____
Birthdate _____ SS #/SIN _____ Employer _____ Date Employed _____
Occupation _____
Insurance Company _____ Group # _____ Employee # _____
Ins. Co. address _____
City _____ State _____ Zip _____
Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Dental & Health History *CONFIDENTIAL* Patient ID # _____

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.

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 Chew hard objects (pencils, etc.) ☐ Yes ☐ No

Suck/Bite lip ☐ Yes ☐ No Grind teeth ☐ Yes ☐ No

Bite/Chew nails ☐ Yes ☐ No Clench jaws ☐ Yes ☐ No

Previous dentist _____ Address _____

Date of last dental visit? _____ _____

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

Child's physician _____ Address _____

Phone # _____ _____

Previous Hospitalizations/Surgeries/Serious Illness? When?

_____ _____

_____ _____

_____ _____

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

_____

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

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 substance (latex, environmental, etc.)?

_____

Has your child ever had any of the following:

Asthma ☐ Yes ☐ No Stomach, liver or kidney problems ☐ Yes ☐ No

Cancer ☐ Yes ☐ No Handicaps/Disabilities ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No Diabetes ☐ Yes ☐ No

Hemophilia ☐ Yes ☐ No Rheumatic Fever ☐ Yes ☐ No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? ☐ Yes ☐ No Congenital Heart Defect ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No

Abnormal Bleeding ☐ Yes ☐ No Convulsions/Epilepsy ☐ Yes ☐ No

Please explain any medical problems that your child has: _____

_____

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 if minor Date

Dentist Review:

_____ _____

Signature of Dentist Date

FAMILY DENTISTRY
HOOPER

YOUR DENTAL INSURANCE IS YOUR RESPONSIBILITY…BUT WE CAN HELP…Regardless of what we might calculate as your dental benefit in dollars, we must stress the fact that you the patient are responsible for the TOTAL TREATMENT FEE. As a courtesy to you, we do accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out-of-pocket expenditures. Any estimate our office gives is based on limited information obtained from your insurance company.

We allow 60 days for your insurance company to make payment. AFTER THIS TIME, ALL INQUIRIES (FOLLOW-UPS) ON PAYMENTS DUE BECOME YOUR RESPONSIBILITY.

Please sign below to confirm acceptance of your financial responsibilities.

_____ _____

Patient's/Guarantee's Signature Date

Hooper Family Dentistry, Inc
5148 Airline Drive
Bossier City, LA 71111

Hooperfamilydentistry.com

(318)742-2272

hooperfamilydentistry@gmail.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly

- Obtain payment from third-party payers

- Conduct Normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices, containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices.

Hooper Family Dentistry
5148 Airline Drive
Bossier City, LA 71111

Alternative Contact/Preferred method of Communication Form

We at Hooper Family Dentistry take your dental confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your dental care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will no leave any dental information with any other person unless you specifically authorize below:

Hooper Family Dentistry, Inc
5148 Airline Drive
Bossier City, LA 71111

Hooperfamilydentistry.com

(318)742-2272

hooperfamilydentistry@gmail.com

☐ I do NOT authorize to receive information regarding my dental care

☐ I authorize my physician and the employee of this office to speak with:

Person:

Relationship:

Phone Number(s):

Check all that apply:

☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Dental Care

☐ Treatment

Please check your preferred methods of communication:

☐ Home Phone (Answering Machine) ☐ Cell phone (voice mail)

☐ Mail ☐ Work Phone

☐ Text Message ☐ Email

Electronic Communication is my preferred method:

◯ Yes ◯ No

(In order to electronically communicate to you or anyone you designate, we are required to have your written permission)

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.

Any problems and/or questions concerning this form are to be referred to the Hooper Family Dentistry staff.

I agree that should I desire to revoke this authorization, I will give written notice.

Signature: _____ Date:

Response Date: