# WELCOME

## 1 About Your Child

Today's Date: ____/____/____ File #:_____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

Child's Home Phone #:(_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

_____

## 2 Insurance Information

### Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? ❑ Yes ❑ No

### Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

## 3 Child's Family Information

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? _____ Age(s): _____ _____ _____

**Mother's Name:** _____
❑ STEP MOTHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long?_____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

**Father's Name:** _____
❑ STEP FATHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long?_____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

## 4 Account Information

**Person ultimately responsible for account**

Name: _____ _____
RELATION TO CHILD

Billing Address: _____

_____
CITY STATE ZIP

_____ ____/____/____ _____
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____)_____ _____ (_____)_____
WORK PHONE #: EXT. CELL PHONE #:

**Payment method:** ❑ Cash ❑ Check

_____ ____/____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

Please Continue On Back

## 5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth ❑ Loose tooth
❑ Other(s):_____

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist:_____ (_____)_____

Last Dental exam:____/____/____ Last Dental X-rays:____/____/____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

## 6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others:_____

Child's Physician:_____ (_____)_____
DOCTOR'S NAME OR CLINIC NAME PHONE#

_____ Last Medical Exam:____/____/____
ADDRESS CITY STATE ZIP

**Does Child have or ever had any of the following diseases, medical conditions or procedures?**

**Y N** Heart Murmur
**Y N** Rheumatic fever
**Y N** Artificial Heart Valves
**Y N** Congenital Heart defect
**Y N** Scarlet Fever
**Y N** Surgeries/Operations
**Y N** Cancer/Tumors
**Y N** Chemotherapy
**Y N** Jaw Problems TMJ/TMD
**Y N** Hearing Problems
**Y N** Tonsillitis
**Y N** Respiratory Problems
**Y N** Asthma/Difficulty Breathing
**Y N** Blood Transfusion(s)
**Y N** Leukemia/Anemia
**Y N** Diabetes/Hypoglycemia
**Y N** Hemophilia
**Y N** Abnormal Bleeding
**Y N** Cleft Lip/Palate
**Y N** Birth Defects
**Y N** High/Low Blood Pressure
**Y N** Hepatitis
**Y N** Artificial Bones/Joints/Implants
**Y N** Liver/Kidney/Organ Problems
**Y N** HIV+/AIDS/ARC
**Y N** Tuberculosis TB
**Y N** Psychiatric Problems
**Y N** Hyper Active/ADD
**Y N** Fainting/Seizures/Epilepsy
**Y N** Cerebral Palsy

Please list any other medical condition(s) child has or ever had:_____

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine)
❑ Aspirin ❑ Food allergies ❑ Other(s):_____

Please rate the child's general health from 1-10:_____ Does child wear contact lenses? ❑Yes ❑No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long?_____ Child's Blood type:_____

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Parent or Guardian ❑ Other:

**UPDATE**
(OFFICE USE)

Initials ____/____/____ Date

Comments

Initials ____/____/____ Date

Comments

Initials ____/____/____ Date

Comments

# PATIENT CONSENT FORM

I UNDERSTAND THAT I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. THESE RIGHTS ARE GIVEN TO ME UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). I UNDERSTAND THAT BY SIGNING THIS CONSENT, I AUTHORIZE YOU TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION TO CARRY OUT:

- TREATMENT (INCLUDING DIRECT OR INDIRECT TREATMENT BY OTHER HEALTHCARE PROVIDERS INVOLVED IN MY TREATMENT)
- OBTAINING PAYMENT FROM THIRD PARTY PAYERS (E.G. MY INSURANCE COMPANY)
- THE DAY-TO-DAY HEALTHCARE OPERATIONS OF OUR PRACTICE

I HAVE ALSO BEEN INFORMED OF, AND GIVEN THE RIGHT, TO REVIEW AND SECURE A COPY OF YOUR *"Notice of Privacy Practices"*, WHICH CONTAINS A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY PROTECTED HEALTH INFORMATION, AND MY RIGHTS UNDER HIPAA. I UNDERSTAND THAT YOU RESERVE THE RIGHT TO CHANGE THE TERMS OF THIS NOTICE FROM TIME TO TIME AND THAT I MAY CONTACT YOU AT ANY TIME TO OBTAIN THE MOST CURRENT COPY OF THIS NOTICE.

I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS ON HOW MY PROTECTED HEALTH INFORMATION IS USED AND DISCLOSED TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS, BUT THAT YOU ARE NOT REQUIRED TO AGREE TO THESE REQUESTED RESTRICTIONS. HOWEVER, IF YOU DO AGREE, YOU ARE THEN BOUND TO COMPLY WITH THIS RESTRICTION.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, IN WRITING, AT ANY TIME. HOWEVER, ANY USE OR DISCLOSURE THAT OCCURED PRIOR TO THE DATE I REVOKE THIS CONSENT IS NOT AFFECTED.

Signed this _____ day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Names of who we may release information to

_____

_____

Comfort Dental of Fort Wayne
3825 W. Jefferson
Fort Wayne, IN 46804

**COMFORT DENTAL of FORT WAYNE**
**Dr. Christopher L. Bible D.D.S**
3825 W. Jefferson Blvd.
Fort Wayne, IN 46804
Phone: (260) 435-1968 Fax: (260)435-1971

- I have come to Comfort Dental of Fort Wayne for dental diagnosis and treatment.
- Payment is expected at the time services are rendered unless prior arrangements are made.
- Dismissal from the practice would be the result of three failed appointments. Failure to provide 48-hour notice of cancellation will be considered a failed appointment.
- Absolutely no food or drink allowed beyond the reception area.
- Unless preapproved, only the patient being treated will be allowed in the operatory.
- I agree to disclose all previous illnesses and medical history. Undisclosed medical information, current medications, allergies or illnesses are risk factors.
- I realize that there are risks associated with dental treatment. Some of those risks include, but are not limited to:
    - Administration of local anesthetic which may cause bruising, hematoma, cardiac stimulation, muscle soreness and temporary/rarely permanent numbness.
    - Allergic reactions from local anesthetic, medicated rinses, latex gloves, prescriptions, medicines or other products used in the treatment of dental conditions.
    - Trauma to adjacent oral structures, such as teeth, gums, tongue, cheek, lip or face.
    - Irreversible pulpitis, necessitating root canal therapy or extraction, due to extent or depth of decay and/or the amount of tooth structure prepared as prescribed for treatment of tooth.
    - Pain or discomfort associated with the TMJ or jaw joint.
    - Elevated tooth sensitivity to hot, cold, sweet, pressure, air, or chewing or biting.
    - Aspiration (breathing in) or swallowing of dental instruments, dental products or tooth structure.
    - Breakage of dental instruments such as root canal files, dental burs or dental hand instruments.
- I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment.
- I understand that should any of these risks occur during or as a result of my dental treatment, the dentist may refer me to a specialist or medical doctor for further treatment of my dental condition and/or any treatment required due to the associated risk.
- I also understand that the dentist may need to change my proposed treatment plan during or after actual treatment. The dentist/dental staff will inform me of the need for change and will discuss any change in cost to myself or my insurance company prior to performing additional treatment.
- I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jaw bones following oral surgery or tooth extractions.
- I do voluntarily assume any and all possible risks of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child/ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me, if necessary, and I have been given the opportunity to ask questions.
- This document will be on file at the dental office and will be applicable to any and all dental treatment during and after patient's treatment at Comfort Dental of Fort Wayne.

I agree to the above statements and give my consent for treatment for myself or my child.

Patient_____ Date:_____

Parent/Guardian:_____ Date:_____