LEGACY HILL
DENTISTRY

Today's Date: _____

Child's Full Name: _____ **Age**: _____

Child's Home Address: _____ **Birthday**: _____

_____ **Child's Social #:** _____

_____

Responsible Party Information:

Mother's Name: _____ **Mother's Birthday:** _____

Mother's Address: _____

Mother's Social #: _____ **Mother's Phone #:** _____

Mother's Email Address: _____

Father's Name: _____ **Father's Birthday:** _____

Father's Address: _____

Father's Social #: _____ **Father's Phone #:** _____

Father's Email Address: _____

Who is responsible for this account? _____

Primary Ins Co: _____ **Subscriber**: _____

Subscriber's Social: _____ **Subscriber Birthday**: _____

Employer: _____ **Group #**: _____

Is patient cover by a secondary insurance company? Yes No

Secondary Ins Co: _____ **Subscriber**: _____

Subscriber's Social: _____ **Subscriber Birthday**: _____

Employer: _____ **Group #**: _____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Legacy Hill Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____ **Date**: _____

Relationship to Patient: _____

Acknowledgement of receipt of Notice of Privacy Practices:

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

Signature: _____ **Date**: _____

Please list all parties/persons we can share your treatment or personal information with:

_____

Dental History:

Is this your child's first visit to the dentist? **Y or N**

Has your child had a bad dental experience? **If yes, please explain**: _____

_____

Reason for today's visit: _____ **Former Dentist**: _____

Date of last dental visit: _____ **Date of last X-rays**: _____

Please list any and all medications your child is currently taking: _____

_____

Please circle yes or no to the following questions:

Has your child ever had any of the following?

Asthma	**Yes or No**	**Rheumatic Fever**	**Yes or No**
Cancer	**Yes or No**	**Congenital Heart Defect**	**Yes or No**
Hepatitis type ___	**Yes or No**	**Handicaps/Disabilities**	**Yes or No**
HIV/AIDS	**Yes or No**	**Convulsions/Epilepsy**	**Yes or No**
Hemophilia	**Yes or No**	**Tuberculosis**	**Yes or No**
Diabetes	**Yes or No**	**Abnormal Bleeding**	**Yes or No**
Heart Murmur	**Yes or No**	**Development Delays**	**Yes or No**

Other: _____

Allergies:

Aspirin	**Y or N**	**Local Anesthetic**	**Y or N**	**Barbiturates**	**Y or N**
Codeine	**Y or N**	**Penicillin**	**Y or N**	**Sulfa**	**Y or N**
Iodine	**Y or N**	**Latex**	**Y or N**	**Other: _____**	

By signing below, I fully understand that Legacy Hill Dentistry has a no-show policy. Within a 24-month period your first no show/cancellation less than 48-hours prior will be a warning, and your second no show/cancellation less than 48 hours will be a charge starting at $50.00 for your missed appointment. This is per patient policy, NOT per family.

Signature: _____

All of the above information is true and accurate to the best of my knowledge.

Completed by: _____ **Date**: _____

Relationship to Patient: _____