



Welcome to the Office of Legacy Hill Dentistry

Please Print

Please Print:

Today's Date: _____
 Child's Name: _____ Sex: _____
 Birthdate: _____ Age: _____
 SS#: _____
 Child's Home Address: _____
 City / State / Zip: _____

Responsible Party Information:

Mother's Name: _____ **SS#:** _____
 Address: _____
 City / State / Zip: _____
 Birthday: _____ Employer: _____
 Home Phone #: _____ Wk #: _____ Cell #: _____

Father's Name: _____ **SS#:** _____
 Address: _____
 City / State / Zip: _____
 Birthday: _____ Employer: _____
 Home Phone #: _____ Wk #: _____ Cell #: _____

Primary Dental Insurance: _____
 Subscriber's Name: _____ Birthday: _____
 SS #: _____ Employer: _____
 Group #: _____ Ins Co Ph #: _____

Secondary Dental Insurance: _____
 Subscriber's Name: _____ Birthday: _____
 SS #: _____ Employer: _____
 Group #: _____ Ins Co Ph #: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign to Dr. Russell/Dr. Burton all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. 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: _____

Acknowledgment of receipt of Notice of Privacy Practices:

I have received of 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? Please explain if yes. _____

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

Date of last Dental visit: _____ Last x-rays: _____

Please list any and all medications your child takes: _____

Please circle yes or no to the following questions:

Has your child ever had any of the following?

- | | | | |
|--------------|--------|------------------------|--------|
| Asthma | Y or N | Rheumatic Fever | Y or N |
| Cancer | Y or N | Cong. Heart Defect | Y or N |
| Hepatitis | Y or N | Handicaps/disabilities | Y or N |
| HIV/AIDS | Y or N | Convulsions/Epilepsy | Y or N |
| Hemophilia | Y or N | Tuberculosis | Y or N |
| Diabetes | Y or N | Abnormal Bleeding | Y or N |
| Heart Murmur | Y or N | Developmental Delays | Y or N |

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: | _____ |

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

Completed By: _____ Date: _____

Relationship to Patient: _____

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 24 hours prior will be a warning, and your second no show/cancellation less than 24 hours prior will be a \$50.00 charge per hour for your missed appointment. This is per patient policy, NOT per family.

X _____