

**PATIENT INFORMATION**

Thank you for choosing our office. In order to serve you properly, we need the following information. Please print. All information will be confidential.

Patient Name: \_\_\_\_\_ MI \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_

Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

ARE THERE ANY SIBLINGS THAT COME HERE: \_\_\_\_\_

Referred by: \_\_\_\_\_

Mother/Legal Guardian's Name: \_\_\_\_\_

Have you ever been a patient here: Yes \_\_\_ No \_\_\_

Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Fathers/Legal Guardian's Name: \_\_\_\_\_

Have you ever been a patient here: Yes \_\_\_ No \_\_\_

Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

**DENTAL INSURANCE INFORMATION:**

Primary Insurance: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_

Claims Address: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Policy No: \_\_\_\_\_ Group No: \_\_\_\_\_

Claims Address: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

Phone: \_\_\_\_\_

I authorize release of any information concerning r my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for Insurance benefits.

I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I recognize that I am responsible to pay any charges not covered by my insurance.

Signature of parent or guardian of minor \_\_\_\_\_ Date \_\_\_\_\_

## Dental & Medical History Information

### Dental History

Patient Name \_\_\_\_\_ Reason for today's visit \_\_\_\_\_

Previous Dentist \_\_\_\_\_ City/State \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Times a day child brushes? \_\_\_\_\_ Flosses? \_\_\_\_\_ Drinks fluoridated water? \_\_\_\_\_

Please check all that apply:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Bad breath            | <input type="checkbox"/> Stained teeth             | <input type="checkbox"/> Clicking or popping jaw |
| <input type="checkbox"/> Mouth breathing       | <input type="checkbox"/> Sores in mouth            | <input type="checkbox"/> Grinding teeth          |
| <input type="checkbox"/> Sensitivity           | <input type="checkbox"/> Broken/loose fillings     | <input type="checkbox"/> Swollen/tender gums     |
| <input type="checkbox"/> Brushing pain         | <input type="checkbox"/> Bleeding gums             | <input type="checkbox"/> Locking jaw             |
| <input type="checkbox"/> Orthodontic treatment | <input type="checkbox"/> Blisters on lips or mouth | <input type="checkbox"/> Lip biting/sucking      |
| <input type="checkbox"/> Ringing in ears       | <input type="checkbox"/> Chew on one side of mouth |  |
| <input type="checkbox"/> Chipped/ Broken tooth | <input type="checkbox"/> Tobacco Use               |  |
| <input type="checkbox"/> Loose teeth           |  |  |

### Medical History

Physician's Name \_\_\_\_\_ City/Phone \_\_\_\_\_

Please check all that apply:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Congenital Heart Defects    | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Down syndrome               | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Fainting                    | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Heart Murmur: PreMed? _____ | <input type="checkbox"/> Sensory Disorder     |
| <input type="checkbox"/> Birth Defects       | <input type="checkbox"/> Hearing Impairment          | <input type="checkbox"/> Surgeries/Operation  |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Tonsillitis          |
| <input type="checkbox"/> Blood Transfusion   | <input type="checkbox"/> Jaw Pain                    | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Cancer: Type _____  | <input type="checkbox"/> Kidney Disease              | <input type="checkbox"/> Visual Impairment    |
| <input type="checkbox"/> Cerebral Palsy      | <input type="checkbox"/> Liver Disease               | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Cleft Lip/Palate    | <input type="checkbox"/> Low Blood Pressure          |   |

Please list any medications that your child is taking: \_\_\_\_\_

### Allergies

Please check all that apply:

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> Amoxicillin        | <input type="checkbox"/> Erythromycin   | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Sulfa        |
| <input type="checkbox"/> Codeine            | <input type="checkbox"/> Latex          | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Metals         | <input type="checkbox"/> Other _____  |

I certify that to the best of my knowledge the questions on this form have been accurately answered. I will not hold Dr. Crisp or any staff member responsible for any action they take or do not take because of errors that I have made in completion of this form. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform this dental office of any changes in my child's medical history.

I authorize the staff to perform any necessary services needed during diagnosis and treatment of my child.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Tim F.Crisp D.M.D.  
11 Canary Lane  
Winchester, KY 40391  
859-744-7031

**Notice of Privacy Practices  
Consent & Authorization**

Tim Crisp D.M.D. reserves the right to speak with a patient's primary care physician at any time to discuss the health and well being of a mutual patient.

We will continue to phone in prescriptions at the parent's request for the patient at the pharmacy of their choice. Signing this consent form gives the office of Dr. Tim Crisp permission.

Patient medical records will NOT be released without prior authorization from the patient's parent or legal guardian. We will accept authorization by mail, fax or from the new dental office treating the patient.

**PATIENT RECORD OF DISCLOSURES**

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I \_\_\_\_\_ am the parent/legal guardian of \_\_\_\_\_  
(Parent or Legal Guardian) (Patient's Name)

I give my permission to be contacted by the following manner:

- Home Telephone
- OK to leave a detailed message?
- Work Telephone
- OK to mail to my home address?

**Other OR Restrictions SUCH AS:** Do not wish to have primary care physician and/or pharmacy contacted.

**We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.**  
**Disclosures that can be made without consent of authorization:** As required during an investigation by law enforcement agencies; As required by military command authorities for their medical records; In response to a legal proceeding; To a coroner or medical examiner for identification of a body; Other covered entities' and providers' payment activities; Uses and disclosure required by law; Uses and disclosures in domestic violence or neglect situations.

**I UNDERSTAND THE POLICY & PROCEDURES OF THE OFFICE OF TIM CRISP D.M.D.**

Patient's Name: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent/Legal Guardian)

Filename: Privacy & Policy/Consent/Authorization

**Tim F. Crisp Pediatric Dentistry**

**11 Canary Lane**

**Winchester KY, 40391**

In the event that I am ever unable to bring my child to his/her appointment the individuals listed below have my permission to bring them and be treated in my absence.

Patient Name: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_

Name	Relationship	Phone Number

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FINANCIAL AGREEMENT**  
**Dr. Tim F. Crisp**

**Patient name:** \_\_\_\_\_

Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining health service. If your insurance company rejects a claim and refuses to pay for a service, it is not a reflection of how important the service is.

Please note our agreement is with you, **NOT** your insurance company. If your insurance company refuses to pay or pays less than estimated, you must remember that dental insurance is designed to offset the costs of your dental treatment. You are responsible for the cost of your treatment and any insurance reimbursement conflicts. Our office staff will help you to the best of our ability to obtain your maximum benefits. *We strongly advise you, as our patient, to familiarize yourself with your dental coverage and your benefits.* If a claim is not paid, you will be responsible for the balance.

We are providing the following payment options, being sensitive to the fact that different people have different needs in fulfilling their financial obligations:

1. We accept Check, Cash, Money Order, Visa, MasterCard, or Discover.
2. We offer interest free extended payment plans through Care Credit.

Please note: Our office has a 24 hour cancellation policy. Your appointment is time reserved especially for you as our patient to provide for your dental needs. We strive to provide you with a courtesy reminder call, however it is ultimately your responsibility to remember your dental appointment. Please note that there is a **\$15.00** fee for appointments cancelled less than a 24 hour notice or **broken** appointments.

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_