Children's Dental Services

Patient Name (print) _____ **Birth Date** _____

☐**Male** ☐**Female**

Parents' Names (print) _____

Address _____ **Email**:_____

Zip Code _____ **Phone** (____)_____ **2nd Phone** (____)_____

What is the Patient's Race? African American ( ) American Indian ( ) Asian ( ) Declined to specify ( )
Hawaii or Pacific Islander ( ) Other ( ) White ( )

What is the Patient's Ethnicity? Declined to Specify ( ) Not Hispanic ( ) Hispanic ( )

What is the Patient's Primary Language? _____

HAS THE PATIENT SEEN THE DENTIST IN THE LAST YEAR? ☐YES ☐NO

Approximate date of last dental visit: _____ **Date of last x-rays:**_____

Name of Clinic: _____

PATIENT MEDICAL HISTORY:

Is the patient having any dental-related pain or concerns? ☐Yes ☐No
If yes, please explain:_____

1. Indicate any of the following that apply to the patient:

ADHD/ADD	☐Yes ☐No	Chemical dependency	☐Yes ☐No	Hemophilia	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Cold sores or fever blisters	☐Yes☐No	Hepatitis/liver disease	☐Yes ☐No
Anemia	☐Yes ☐No	Congenital heart disease	☐Yes☐No	High blood pressure	☐Yes ☐No
Artificial heart valve	☐Yes ☐No	Dental anxiety	☐Yes☐No	Kidney disease	☐Yes ☐No
Artificial joint	☐Yes ☐No	Developmental disability	☐Yes☐No	Radiation/chemotherapy	☐Yes ☐No
Arthritis	☐Yes ☐No	Depression/psychiatric	☐Yes☐No	Rheumatic fever	☐Yes ☐No
Asthma/Wheezing	☐Yes ☐No	Diabetes	☐Yes☐No	Thyroid disease	☐Yes ☐No
Autism spectrum	☐Yes ☐No	GERD	☐Yes☐No	Tuberculosis (TB)	☐Yes ☐No
Blood transfusion	☐Yes ☐No	Epilepsy or seizures	☐Yes☐No	Rash/hives,eczema/skin problems	☐Yes ☐No
Cancer	☐Yes ☐No	Heart murmur	☐Yes ☐No	STIs	☐Yes ☐No

Please explain any boxes marked yes: _____

2. Does the patient have any disease, condition, or problem not listed? ☐Yes ☐No
If yes, please list _____

3. Does the patient have any allergies to food, drugs or medicines? ☐Yes ☐No
If yes, to what and how do you/ your child react? _____

4. Is your child allergic to latex or anything else such as metals, acrylic, or dye? ☐Yes ☐No
Is your child allergic to Silver? ☐Yes ☐No If yes please list _____

5. Is the patient taking any medicines, drugs, herbal supplements or vitamins? ☐Yes ☐No
If yes, list all medications _____

6. Has the patient ever had any unusual reaction to a dental anesthetic? ☐Yes ☐No

7. Has the patient ever had any excessive bleeding requiring special treatment? ☐Yes ☐No

8. Has the patient seen a physician within the past 2 years? ☐Yes ☐No
If yes, for what reason? _____

9. Has the patient been hospitalized within the past 2 years? ☐Yes ☐No
If yes, for what reason? _____

10. Has the patient ever had any operations or surgery? ☐Yes ☐No
If yes, what was the reason? _____

Were there any complications? (describe)_____

11. Is your child up to date on immunizations against childhood diseases? ☐Yes ☐No

12. Is the patient pregnant now or possibly pregnant? ☐Yes ☐No ☐N/A
If yes, when is your due date? _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered.
I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. CDS will typically process Release of Records and Referrals within 48 hours.

_____ _____ _____ _____
Signature of parent/guardian **Relationship to child** **Date** **Signature of staff member**

PATIENT REGISTRATION

PATIENT INFORMATION:

Patient name: _____
(First) (Last)
Parent/Guardian Name: _____

Address: _____City: _____Zip Code: _____

Phone number: _____ Other Phone Number: _____

Where does your child attend school? _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____City: _____Zip Code: _____

Phone number: _____

PAYMENT INFORMATION:

_____ No Insurance

_____ State Covered Insurance (MA), PMI # or ID #: _____.

_____ Private insurance, fill out information below:

Insurance Carrier (private ins.) Name: _____

Insurance Carrier Phone Number: _____

Employer: _____ Employee Name: _____

Employee Social Security Number/Insurance ID #: _____

Employee Date of Birth: _____

***If you would like to give permission to someone else to bring your child to the Dentist please fill out the following:**

_____ has my permission to bring my child _____
(Name/Relationship) (Child's Name)
to the dentist without my presence.

_____
(Parent/Guardian Signature)

I understand it is my responsibility to update CDS with any new information as needed. All information is

current and accurate as of today's date _____ _____
(Parent/Guardian Signature)

Patient's Rights and Responsibilities

Patient's Rights and Responsibilities

Welcome and thank you for choosing Children's Dental Services (CDS) for your dental care. We are a private non-profit dental clinic that accepts most dental insurances including Minnesota Health Care Programs. CDS is dedicated to improving the oral health of children from families with low incomes by providing accessible treatment and education in our diverse Minneapolis/St. Paul community.

Patient Rights: As a CDS patient, you may expect to receive professional, culturally sensitive, and quality care by licensed dentists. You may expect to be treated respectfully and professionally. CDS does not discriminate based on race, creed, color, religion, sex, national origin, age, marital status, sexual orientation, disability, or status with regard to public assistance. No appointments will be denied for those reasons. You also may expect patient confidentiality. No dental record or x-rays will leave CDS without your verbal or written consent. You may also expect full understanding of your dental care and general oral health. However, if you do not understand, let the dental staff know.

Patient Responsibilities: In order to ensure quality care and good oral health, and to maintain a mutually respectful atmosphere, please observe the following guidelines: You are responsible to maintain all appointments. Due to the high volume of people seeking dental care, CDS will not tolerate repeated failed appointments. CDS will try to make a courtesy call three business days before an appointment to remind you of the appointment; however, if we are unable to connect with you, **it is your responsibility to call and confirm the appointment by 12:00 pm one business day before the appointment. If you fail to do so, your appointment slot is not guaranteed to you and may be given to someone else. If you need to cancel your appointment you must do so by 12:00 pm one business day before; otherwise, it is considered a broken/failed appointment. It is also a broken/failed appointment if you are more than 10 minutes late to an appointment and we are unable to see your child. After two failed appointments within 18 months we may not see the patient for six months**. In order to maintain accurate records, it is your responsibility to provide current necessary information to the dental team (i.e. address, phone number, medical history, dental history, insurance information). Lastly, it is your responsibility to obtain a full understanding of the dental diagnoses and treatment. If this is unclear to you, please let the dental team know. As parent or legal guardian you consent to the dental treatment plan determined by CDS for your child, or yourself if you are an adult (pregnant), to receive treatment under that plan. Children's Dental Services is pleased to provide care under a Collaborative Agreement between its dentists and hygienists, under which Registered Dental Hygienists provide an advanced level of dental care. Hygiene visits do not take the place of a visit to the dentist. For those that have private/commercial insurance, it is your responsibility to know what your dental insurance policy will and will not cover.

CDS has Minnesota Health Care Programs (MHCP) and Assured Access application forms if you do not have dental insurance. If you do not qualify for MHCP and do not live in Hennepin County, CDS offers a sliding scale for qualifying patients without insurance. Please ask about it if you are interested. Patients with outstanding balances may not receive future appointments until a payment plan is in place or the account is current.

CDS legally has the responsibility to report any suspected child abuse and or neglect to the appropriate officials. Failure to get your child the treatment needed will likely be considered child neglect.

In most cases, CDS requests that a parent or guardian accompany the child to each appointment if he/she is under the age of 14. In order to provide the safest, most effective treatment for your child we may use physical restraint and/or nitrous oxide. CDS will not render services if the child is not present with a parent or legal guardian, unless consent is provided, allowing another adult to be present. A child over the age of 16 may be seen alone only with a signed, written permission from the parent/guardian and a phone number where the parent/guardian may be contacted for questions. Regardless of the patient's age, CDS requests that the parent/guardian be present at the INITIAL appointment.

We truly appreciate the trust you have shown us by allowing us to treat you/your child. If you have ANY questions about our policies, please ask us right away. We will be happy to discuss your concerns!

Your signature below indicates that you have read, understand, and accept the rights and responsibilities listed above.

_____ _____

Patient Name (print) Parent/Guardian Name (print)

_____

Parent/Guardian Signature

Children's Dental Services

Acknowledgement of Receipt of Notice of Privacy Practices

*** You may refuse to sign this document***

I have received a copy of Children's Dental Services Notice of Privacy Practices.

_____
printed name of parent or legal guardian

_____ _____
signature of patient's parent or legal guardian *name of patient*

_____
relationship to patient

_____
Date

For Office Use Only

Documentation of Good Faith Efforts

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because _____:
guardian name

☐ Individual refused to sign or initial

☐ Communications barriers prohibited obtaining the acknowledgment

☐ An emergency situation prevented us from obtaining the acknowledgment

☐ Patient was unable to sign or initial because:
_____
_____

☐ Other reason described below:
_____