

PATIENT INFORMATION

Patient's Name: _____ Sex: _____ Date of Birth: _____
Child likes to be called: _____
Complete Address of Child: _____
Names and ages of Siblings: _____
Who may we thank for referring you to our office? _____

RESPONSIBLE PARTY INFORMATION

Father's Full Name: _____	Marital Status: _____
Home Address: _____	Social Security Number: _____
Name of Employer: _____	Occupation: _____
Home Telephone: _____	Work Telephone: _____
Cellular Number: _____	Pager Number: _____
Mother's Full Name: _____	Marital Status: _____
Home Address: _____	Social Security Number: _____
Name of Employer: _____	Occupation: _____
Home Telephone: _____	Work Telephone: _____
Cellular Number: _____	Pager Number: _____

DENTAL INSURANCE INFORMATION

Insurance Holder's Name: _____	Relationship to Patient: _____
Social Security Number: _____	Date of Birth: _____
Name of Employer: _____	Insurance Company: _____
Insurance Company Address: _____	Group Number: _____

DO YOU HAVE DUAL INSURANCE? YES _____ NO _____ If yes, please complete.

Insurance Holder's Name: _____	Relationship to Patient: _____
Social Security Number: _____	Date of Birth: _____
Name of Employer: _____	Insurance Company: _____
Insurance Company Address: _____	

DENTAL INSURANCE INFORMATION

In case of emergency, whom other than parents, may be notified? _____
Relationship: _____ Telephone: _____

The above statements are true and correct. I hereby authorize the doctors of this office, if they should choose, to initiate a review of my credit history, realizing that any such information will be treated confidentially. I understand that balances remaining over 30 days from billing will be subject to interest at 1.5% per month, and agree to pay any and all collection or legal costs incurred should this account be deemed uncollectible. Please remember that insurance is considered a benefit and a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some Insurance companies pay fixed allowances for certain procedures and others pay a percentage of the charges. It is your responsibility to know your policy and to pay any deductible amount, percentage or other balances not paid for by your insurance company at the time of services unless other arrangements have been made.

Signature of Parent or Legal Guardian

Date

TO THE PARENT OR GUARDIAN OF THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our notice provides a description of our treatment, payment activities, and healthcare operations. Of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person: Monica A. Kennard, D.D.S.

Telephone: 952-475-3135

Fax: 952-475-1936

Address: 250 Central Ave. N. Suite #211 Wayzata, MN. 55391

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in regards to this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.**

Health Information

Patients's Name _____ Was this child adopted? _____ If so, at what age? _____

Name/Address of Physician _____ Telephone _____

Date last seen _____ Reason _____

HISTORY

	Yes	No	
1. Is your child being treated by a physician at this time? If yes, why _____	___	___	Reviewer's comments:
2. Has your child ever been a patient in a hospital? If yes, why _____	___	___	
3. Has your child ever received anesthesia or sedation? If yes, when _____	___	___	
4. Is your child allergic to anything? (medicine, food)	___	___	
5. Is your child taking any medicines at this time? If yes, what? _____	___	___	
6. Has your child ever had a blood transfusion?	___	___	
7. Does your child smoke or use tobacco products?	___	___	
8. Does your child have any behavioral or developmental problems? If yes, what? _____ _____			

ORGANS AND SYSTEMS

Has this child ever had any treatment for any of the following? Please check Yes or No:

Yes	No		Yes	No	
___	___	Blood - Chemistry	___	___	Stomach
___	___	Bones	___	___	Kidney - Bladder
___	___	Endocrine Glands	___	___	Heart
___	___	Eyes, Ears, Nose, Throat	___	___	Liver
			___	___	Muscles
			___	___	Nervous System
			___	___	Skin
			___	___	Tonsils, Adenoids

ILLNESS

Has this child ever been diagnosed as having any of the following conditions? Please check Yes or No:

Yes	No		Yes	No	
___	___	AIDS	___	___	Pregnancy
___	___	Anemia	___	___	Psychiatric Disorder
___	___	Allergy	___	___	Rheumatic Fever
___	___	Arthritis	___	___	Scarlet Fever
___	___	Asthma	___	___	Scoliosis
___	___	Autism	___	___	Sickle Cell Anemia
___	___	Brain Injury	___	___	Sinus Problems
___	___	Bronchitis	___	___	Snoring at Night
___	___	Cancer	___	___	Sore Throats - frequent
___	___	Cerebral Palsy	___	___	Spina Bifida
___	___	Chicken Pox	___	___	Syndrome _____
___	___	Cleft Lip/Palate	___	___	Tetanus
___	___	Convulsions/Seizures	___	___	Tuberculosis
___	___	Diabetes	___	___	Venereal Disease
___	___	Diphtheria	___	___	Whooping Cough
___	___	Drug or Alcohol Abuse	___	___	Other _____
___	___	Epilepsy	___	___	Other _____

