

## 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: _____
<b>DO YOU HAVE DUAL INSURANCE? YES _____ NO _____ If yes, please complete.</b>	
Insurance Holder's Name: _____	Relationship to Patient: _____
Social Security Number: _____	Date of Birth: _____
Name of Employer: _____	Insurance Company: _____
Insurance Company Address: _____	

## EMERGENCY CONTACT 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: Taylor Stephens, D.D.S., P.A.

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

Patient's Name \_\_\_\_\_ Was this child adopted? \_\_\_\_\_ If so, at what age? \_\_\_\_\_

Name/Address of Physician \_\_\_\_\_ Telephone \_\_\_\_\_

Date last seen \_\_\_\_\_ Reason \_\_\_\_\_

### HISTORY

**Yes    No    Reviewer's comments:**

- |    |   |     |     |  |
|----|---|-----|-----|--|
| 1. | Is your child being treated by a physician at this time?<br>If yes, why _____               | ___ | ___ |  |
| 2. | Has your child ever been a patient in a hospital?<br>If yes, why _____                      | ___ | ___ |  |
| 3. | Has your child ever received anesthesia or sedation?<br>If yes, when _____                  | ___ | ___ |  |
| 4. | Is your child allergic to anything? (medicine, food)  | ___ | ___ |  |
| 5. | Is your child taking any medicines at this time?<br>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? _____<br>_____ | ___ | ___ |  |

### ORGANS AND SYSTEMS

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

Yes	No		Yes	No		Yes	No	
___	___	Blood - Chemistry	___	___	Stomach	___	___	Muscles
___	___	Bones	___	___	Kidney - Bladder	___	___	Nervous System
___	___	Endocrine Glands	___	___	Heart	___	___	Skin
___	___	Eyes, Ears, Nose, Throat	___	___	Liver	___	___	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		Yes	No	
___	___	AIDS	___	___	Eye Problems	___	___	Pregnancy
___	___	Anemia	___	___	Excessive Bleeding	___	___	Psychiatric Disorder
___	___	Allergy	___	___	Fainting	___	___	Rheumatic Fever
___	___	Arthritis	___	___	Hearing Loss	___	___	Scarlet Fever
___	___	Asthma	___	___	Heart Disease	___	___	Scoliosis
___	___	Autism	___	___	Hemophilia	___	___	Sickle Cell Anemia
___	___	Brain Injury	___	___	Hepatitis - Type _____	___	___	Sinus Problems
___	___	Bronchitis	___	___	Jaundice	___	___	Snoring at Night
___	___	Cancer	___	___	Leukemia	___	___	Sore Throats - frequent
___	___	Cerebral Palsy	___	___	Measles	___	___	Spina Bifida
___	___	Chicken Pox	___	___	Mental Retardation	___	___	Syndrome _____
___	___	Cleft Lip/Palate	___	___	Mumps	___	___	Tetanus
___	___	Convulsions/Seizures	___	___	Mouth Breathing	___	___	Tuberculosis
___	___	Diabetes	___	___	Nutritional Deficiency	___	___	Venereal Disease
___	___	Diphtheria	___	___	Orthopedic Problems	___	___	Whooping Cough
___	___	Drug or Alcohol Abuse	___	___	Pneumonia	___	___	Other _____
___	___	Epilepsy	___	___	Polio	___	___	Other _____

## Dental Information

1. Is this your child's first visit to a dentist?     Yes     No
  2. If not, name of previous dentist \_\_\_\_\_ How long ago? \_\_\_\_\_
  3. Was dental treatment completed? \_\_\_\_\_ Were any of the dental visits unhappy? \_\_\_\_\_  
Reason for leaving? \_\_\_\_\_
  4. What is your primary reason for seeking dental care? \_\_\_\_\_
  5. Has your child complained of any dental problems? \_\_\_\_\_
  6. Any history of injury to the mouth, teeth, or jaw? \_\_\_\_\_ Please explain \_\_\_\_\_
  7. Any history of headaches, bruxism, or TMJ/TMD problems? \_\_\_\_\_
  8. Has your child ever had any of the following? If so, please check:  

<input type="checkbox"/> dental cavities	<input type="checkbox"/> toothaches
<input type="checkbox"/> abscesses (gum boils)	<input type="checkbox"/> cold sores (fever blisters)
<input type="checkbox"/> stained teeth	<input type="checkbox"/> bad breath
  9. Does (or did) your child have habits which might affect oral health?  

<input type="checkbox"/> clenching or grinding teeth	<input type="checkbox"/> mouth breathing
<input type="checkbox"/> finger or thumb habits	<input type="checkbox"/> other _____
  10. Does your child brush daily? \_\_\_\_\_ Do you assist? \_\_\_\_\_ Is dental floss used? \_\_\_\_\_
  11. Do you drink city water, well water, or bottled water? \_\_\_\_\_
  12. How would you describe your child's eating and snack habits? \_\_\_\_\_
  13. What is your child's attitude toward today's visit? \_\_\_\_\_
  14. Does your child have problems in     concentrating     learning     cooperating     understanding?
  15. Is there anything else that you think we should know about your child? \_\_\_\_\_
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**Because your child is a minor, it is necessary to obtain signed permission from a parent or legal guardian.**

**The above statements are, to the best of my knowledge, true and correct. I agree to report any health changes to the dentist before any further treatment is performed. I hereby authorize Dr. Kennard associates, and the staff to provide any examinations, x-rays, and procedures to diagnose oral and dental disease, and to provide necessary dental services with the exception of (if none, please so state):**

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**This consent shall remain in full force and effect until cancelled.**

\_\_\_\_\_  
*Patient's Name*

\_\_\_\_\_  
*Signature of Parent or Legal Guardian*

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