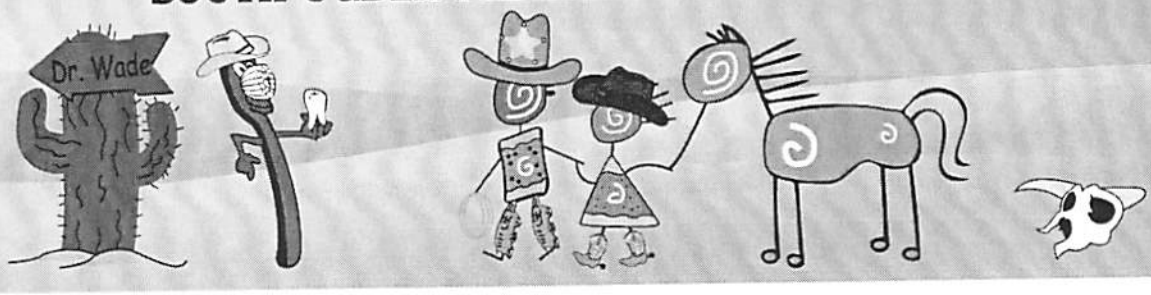
WELCOME TO

SOUTH OGDEN PEDIATRIC DENTAL



Childs Full Name: _____

Date of Birth: ___/___/___ Age: ____ Sex: M F Home Phone (___) ____-_____

Address: _____

_____

Parent/Legal Guardian Information

Mother's Marital Status: ____ Married ___Divorced ___Separated ___Widowed ___ Single

Name:_____

Date of Birth: ___/___/_____ Social Security Number: _____-_____-_____

Address: _____

_____

Home Phone: (____)____-_____ Cell Phone: (____)____-_____ Work Phone: (____)____-_____

Employer: _____

Mother's Spouse:

Name:_____

Date of Birth: ___/___/_____ Social Security Number: _____-_____-_____

Address: _____

_____

Home Phone: (____)____-_____ Cell Phone: (____)____-_____ Work Phone: (____)____-_____

Employer: _____

Father:

Father's Marital Status: ____ Married ___Divorced ___Separated ___Widowed ___ Single

Name:_____

Date of Birth: ___/___/_____ Social Security Number: _____-_____-_____

Address: _____

_____

Home Phone: (____)____-_____ Cell Phone: (____)____-_____ Work Phone: (____)____-_____

Employer: _____

Father's Spouse:

Name:_____

Date of Birth: __/__/____ Social Security Number: _____-_____-_____

Address: _____

_____

Home Phone: (___)___-_____ Cell Phone: (___)___-_____ Work Phone: (___)___-_____

Employer: _____

Who is the child currently residing with? _____

Do you have a Divorce Decree or Child Custody Agreement? Yes_____ No_____

If so, please send the Divorce Decree or Custody Agreement to: OfficeManager@sopediatricdental.com

Dental Insurance:

Primary Coverage
Company:_____

Policy Holder: _____

ID Number_____

Group Number_____

Secondary Coverage
Company:_____

Policy Holder:_____

ID Number_____

Group Number_____

Emergency Contact

Name:_____

Relationship to the Child:_____ Phone: (___)___-_____

To the best of my knowledge, I have provided you with the most accurate information.

Signature:_____ **Date**_____

Relationship to child_____

P.S. How did you hear about us? _____

_____

Thanks a bunch!

SOUTH OGDEN
PEDIATRIC DENTAL
5275 SOUTH ADAMS AVE · SUITE C
WASHINGTON TERRACE · UT 84405

Please Read Office Policies and Federal Truth-in-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. Patient co-payments (the amount not covered by insurance) are due and payable at the time of service.

All emergency dental service, or any dental service performed without previous financial arrangements, must be paid for at the time of services rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service. Fee estimates for the dental care can only be extended for a period of three months from the date of the patient examination. Be aware that treatment needed may change due to new information discovered during the appointment. Those additional services performed are also due at time of service.

In consideration for the professional services rendered to me, or at my request for my minor child or ward by the dentist, I agree to pay the reasonable balance of said services to said dentist or his assignee at the time said services are rendered or within thirty (30) days of billing if credit shall be extended. I further agree that the reasonable values of said services shall be as billed unless objected to by me in writing within the time for payment thereof. Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.

I grant permission to you or your assignee to telephone me at home or at my workplace to discuss matters relating to this form.

I authorize assignment or payment of all dental and/or surgical benefits to which I or other family members are entitled, including private dental insurance and other group health plan benefits otherwise payable to the undersigned, South Ogden Pediatric Dental P.C.

I certify that I have answered all questions on the form accurately and I hereby agree to abide by the conditions outlined therein.

PLEASE SIGN:

_____ _____ _____

Signature of Parent of Guardian | Date | Patient Name

_____

Relationship to Patient

_____ _____

Witness Signature | Date

South Ogden Pediatric Dental P.C.

Pediatric Medical History

Patient Name: Birth Date: Date Created:

Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

General Single Questions

Is your child under a physicians care for anything other then routine check ups?	◯ Yes ◯ No	If yes
Has your child ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Has your child ever had a serious head or neck	◯ Yes ◯ No	If yes
Is your child taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Is your child on a special diet?	◯ Yes ◯ No	If yes

Medical Diagnosis

Has your child been diagnosed with any of the following?

☐ ADD or ADHD ☐ Autism ☐ Bi-polar ☐ Learning Disability
☐ Development delays ☐ Downs Syndrome ☐ Fetal Alcohol Syndrome

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Amoxicillin
☐ Keflex

Other allergies. ☐ If yes

Please check all that apply to your child.

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No
Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No
High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No
Hives or Rash	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No
Ulcers	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No
Yellow Jaundice	◯ Yes ◯ No	Snoring	◯ Yes ◯ No				

Has your child ever had any serious illness not listed above? ◯ Yes ◯ No If yes

To the best of my knowledge, the questions have been accurately answered. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent or Guardian:

X

Date:_____

SOUTH OGDEN
PEDIATRIC DENTAL

Please Read Health Questionnaire and Acknowledgement with Consent to Proceed

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointments.

I authorize Dr. M. Wade Rallison, D.D.S. and/or such associates or assistants as she/he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, other pharmaceutical agents including those related to restorative, palliative, therapeutic, and surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventative procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated, (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and, in rare cases, may require bronchoscope or other procedures to ensure safe removal.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

I understand that there may be a $25.00 charge for missed appointments. Patients that are 15 minutes late to an appointment may be required to reschedule that appointment.

24 business hours advanced notice is required to cancel or reschedule an appointment.

A patient may be dismissed from our practice for two missed appointments per year.

A patient may be dismissed from our practice for missing a sedation or GA Case without cause.

PLEASE SIGN BELOW:

_____ _____ _____

Signature of Parent or Guardian | Date | Relationship to Patient

_____

Patient's Name

_____ _____

Witness Signature | Date

SOUTH OGDEN
PEDIATRIC DENTAL
5275 SOUTH ADAMS AVE • SUITE C
WASHINGTON TERRACE • UT 84405

HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operations of your practice

I have also been informed of, and/or given the right to review and secure a copy of your **Notice of Privacy Practice**, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that I am not required to agree to these requested restrictions. However, if I do agree, I am then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Please sign below:

_____ _____

Signature Date

_____ _____

Printed Name Patient's Name