FAMILIES FIRST PEDIATRICS | FAMILIES FIRST COUNSELING SERVICES | FAMILIES FIRST PEDIATRIC DENTISTRY AND ORTHODONTICS

**CHILD'S INFORMATION:**

**NAME:** First ______________________ MI ____ Last ____________________________________ DOB ____/____/_______

Home Address: ____________________________________________________________________________________________

City: _____________________________________ State: __________ Zip: ________ Child lives with: _________________

Marital status of parents (circle one): Married Single Divorced Separated Widowed Prefer not to answer

**ETHNICITY:** Hispanic Latino Not Hispanic or Latino **GENDER IDENTITY:** M F Other _________________________

**RACE:** White African American American Indian Asian Native Hawaiian Other _____________________________

**PREFERRED LANGUAGE:** English Spanish Other ___________________

**PARENT INFORMATION**

**NAME:** First ______________________ MI ____ Last ____________________________________ DOB ____/____/_______

Home Address (if different from child's): ____________________________________________________________________

City: _______________________________________ State: __________ Zip: _______ Employer: ____________________

Home Phone: _______________________ Cell Phone: _______________________ Work Phone: ____________________

E-Mail: ____________________________________________________________________________________________________

**NAME:** First ______________________ MI ____ Last ____________________________________ DOB ____/____/_______

Home Address (if different from child's): ____________________________________________________________________

City: ______________________________________ State: ___________ Zip: _______ Employer: ____________________

Home Phone: _______________________ Cell Phone: _______________________ Work Phone: ____________________

E-Mail: ____________________________________________________________________________________________________

**Families First Pediatrics, Counseling and Pediatric Dentistry are committed to using the most up-to-date and convenient communication methods for our patients. By selecting "Yes" below, you authorize the use of your mobile number to receive scheduling, billing, and other information important to the health needs of your child.**

**I authorize the use of my mobile number for these purposes** (circle one): Yes No INITIALS _______

**INSURANCE INFORMATION**

**PRIMARY:** Name _____________________________________________________ Insurance Phone # _________________

Policy Holder Name: ___________________________________________________ Policy Holder DOB: ____/____/_______

Insurance Address: ____________________________________________________ City, State, Zip: ____________________

Insurance ID #: ________________________________________________________ Group #: __________________________

**SECONDARY:** Name ___________________________________________________ Insurance Phone # _________________

Policy Holder Name: ___________________________________________________ Policy Holder DOB: ____/____/_______

Insurance Address: ____________________________________________________ City, State, Zip: ____________________

Insurance ID #: ________________________________________________________ Group #: __________________________

**Emergency Contact Name:** _______________________________________ **Relationship:** ___________________________

**Phone Number:** ______________________ **OK to discuss billing/appointments (circle one):** Yes No Initials _______

**How did you hear about our office?** Website Friend/Family Hospital Mailer Other: _________________________

**Does your child currently have any medical or dental concerns?** Yes No

**Has your child seen a Pediatric Dentist in the last 6 months?** Yes No

**Would you like to be contacted about scheduling an appointment with Families First Pediatric Dentistry?** Yes No

## PATIENT FINANCIAL AGREEMENT

As the patient's financial representative, **you are responsible for knowing your insurance coverage and benefits**, and you agree to the following:

**General Terms and Conditions:**

- You authorize care and treatment by our office and release of all information to insurance and third-party carriers and direct them to remit payments directly to our office.
- As a courtesy our office will bill your insurance company, however, if payment is not received within 60 days it is your responsibility to contact your insurance or remit payment in full.
- **It is your responsibility to know what charges are not covered by your insurance and inform our staff before going back for your appointment.**
- Our office will not be involved with separation or divorce disputes. Therefore, the parent who consents to the treatment of a minor child is responsible for payment of services rendered.

**Financial Implications:**

- Payment and/or copay is due at the time of serviced. If the copay is not paid at the time of service a $10.00 fee will be assessed to the account.
- A $25.00 fee will be assessed on all returned checks.
- There may be an after-hours fee of up to $35.00 for visits after 6:00pm and on Saturdays.
- If your account is in good standing with no history of collections or bankruptcy, our office will extend credit on your behalf for a maximum of six months with a minimum monthly payment of $50.00 or 1/6th of the account balance, whichever is greater.
- Accounts past 90 days will be charged an interest rate of 1.5% monthly (18% annually), plus any certified letter fees.
- If the account is assigned to an agency for collections, it is agreed that the financial representative will pay all attorney fees, with or without suit, court costs, a certified letter fee of up to $5.00 and a collection fee of up to 40% of the balance.
- Uninsured patients will receive a time-of-service discount if charges are paid in full at the time of service.
- There may be a fee of up to $25.00 for **complete** medical records, plus any postage if mailed.
- Appointments must be cancelled 48 hours prior to the scheduled appointment time. In the event a patient arrives late and cannot be seen by their therapist for the full appointment time or does not call to cancel within the 48-hour timeframe a charge of up to $100.00 will be assessed to the account.

**Patient Name (please print):** ________________________________________________________ **DOB:** ____/____/________

**Signers Name (please print):** ________________________________________________________ **Date:** ____/____/________

**Signature:** ______________________________________________________ **Relationship to Patient:** ____________________

## HIPAA ACKNOWLEDMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my Protected Health Information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand by signing this consent I authorize you to used and disclose my child's protected health information to conduct:

- Treatment (including direct or indirect treatment by 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 understand that I have a right to receive a more detailed explanation of the Families First Pediatrics' privacy practices prior to signing this consent. I also understand that the terms of the *HIPAA Notice of Privacy Practices* may change and that I may request a revised notice by contacting the department listed below and that a revised notice will be available in the patient waiting area of the Families First Pediatrics' office.

I understand that I have the right to request that the Families First Pediatrics' restrict how it uses and discloses my Protected Health Information (PHI) in order to conduct treatment, payment, or health care operations. I understand that Families First Pediatrics is not required to agree to the restrictions, but that if Families First Pediatrics agrees, the restriction is binding. I understand that I have a right to revoke this consent, but that I must do so in writing. I also understand that a revocation applies to Families First Pediatrics' use and disclosures made after the revocation is made.

**Patient Name (please print):** ______________________________________________ **DOB:** _____/_____/__________

**Signers Name (please print):** ______________________________________________ **Date:** _____/_____/__________

**Signature:** ________________________________________________ **Relationship to Patient:** ___________________

## HEALTH HISTORY

### DENTAL HISTORY

Has your child been to the dentist before? Y N

Is your child currently taking fluoride? Y N If yes, how often? ______________________________________

Has your child had X-Rays before? Y N If yes, how was their experience? ________________________

Is your child currently using a bottle? Y N Pacifier Y N Nursing Y N Sippy cup Y N

Does your child grind their teeth? Y N Suck their thumb? Y N

Do you currently help your child brush and floss? Y N

How often does your child (or you help your child) brush and floss? ____________________________________________

### MEDICAL HISTORY

Has your child seen their Primary Care Physician for a Well Child Check in the last 12 months? Y N

Any recent surgeries? Y N Have you traveled outside of the US in the last 6 months? Y N

Are your child's immunizations up to date? Y N If no, what is needed? ____________________________

Is your child currently taking any medication? Y N If yes, what? ____________________________________

Has your child ever been hospitalized? Y N If yes, why? ____________________________________________

Has your child ever had a traumatic medical/dental injury? Y N If yes, what happened? ___________________________

____________________________________________________________________________________ Date: _____________

DOES YOUR CHILD HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING? (circle all that apply)

| | | |
|---|---|---|
| ADD/ADHD | Endocrine System | Mental Disorder |
| Allergies* | Epilepsy | Multiple Ear Infections |
| Anemia | Excessive Bleeding | Pacemaker |
| Arthritis | Fainting | Radiation Treatment |
| Artificial Joints | Frequent Headaches | Rheumatic Fever |
| Asthma | GI System* | Rheumation |
| Autism | Glaucoma | Seizure |
| Behavioral Disorder | Hay Fever | Sinus Problems |
| Birth Defects* | Head Injuries | Stroke |
| Blood Disease | Hearing/Sight | Tuberculosis |
| Blood Transfusion | Heart Condition* | Tubes in Ears |
| Breathing/Lung Problems | Heart Disease | Tumors/Cysts* |
| Cancer/Tumor* | Heart Murmur | Ulcers |
| Codeine Allergy | Hepatitis | Vomiting/Diarrhea |
| Cystic Fibrosis | HIV | Other ________________________________ |
| Developmental Delay | Jaundice | Other ________________________________ |
| Diabetes | Kidney Disease | Other ________________________________ |
| Dizziness | Latex Allergy | Other ________________________________ |
| Down Syndrome | Medicine Allergy* | Other ________________________________ |

**If you checked any with an *, please explain:** ____________________________________________________________________

**Patient Name (please print):** _______________________________________________________ **DOB:** ____/____/______

**Signers Name (please print):** _______________________________________________________ **Date:** ____/____/_______

**Signature:** ______________________________________________________ **Relationship to Patient:** _________________