



To help us better serve you, please complete the following forms to the best of your ability.  
If you have questions, do not hesitate to let us know. Thank you for choosing our office!

Child's Name: \_\_\_\_\_ DOB (MM/DD/YY): \_\_\_\_\_

Nickname: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Ethnicity:  Hispanic/Latino  Non-Hispanic/Latino  Declined Gender:  Male  Female  Other  Undecided

Race:  White  Black/African American  American Indian  Asian  Native Hawaiian  Pacific Islander  
 Other  Declined

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Who can we thank for referring you to us? (Please check all that apply.)

Primary Care Doctor \_\_\_\_\_  
 General Dentist \_\_\_\_\_

Friend/Family \_\_\_\_\_  
 School/Daycare \_\_\_\_\_

How have you heard about us? (Please check all that apply.)

Social Media  
 Google/Website  
 Insurance Directory  
 Drive-by/Signage  
 Billboard

Newspaper or magazine feature/ad  
 School/Daycare  
 Community Event/Festival  
 Commercial or video  
 Other \_\_\_\_\_

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Mother/Guardian)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Address (if different than child): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Father/Guardian)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Address (if different than child): \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**PRIMARY DENTAL INSURANCE:**

Insurance Company: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Subscriber's ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE:**

Insurance Company: \_\_\_\_\_ Insured's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Employer: \_\_\_\_\_ Subscriber's ID: \_\_\_\_\_ Group #: \_\_\_\_\_

**FINANCIAL ARRANGEMENTS/INSURANCE AGREEMENT**

I authorize the treating provider to release any information, including the diagnosis and the records of treatment or examination rendered to my child during the period of such care, to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

Any unpaid balance due (as listed on a billing statement), not paid within 28 days of the monthly billing date, will be assessed a late charge of 1.5% each month. I realize that failure to keep this account current may result in my children being unable to receive additional dental services except for dental emergencies or when there is pre-payment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection cost (33% of the unpaid balance), postage, attorney, and court fees incurred in attempting to collect on this amount or any future outstanding balances.

I hereby authorize the office to contact the designated phone numbers and/or email address listed in the patient's account. With this authorization, a message/communication may be left indicating appointment time and dates, reminders, balances due, and/or estimated co-pays for future visits.

Financially responsible person for account  Self  Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent or Legal Guardian\_\_\_\_\_  
Date Child in foster care - Children & Youth and Foster Parents will not sign

Staff Initials \_\_\_\_\_

**ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES****PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protection health information to carry out treatment, payment activities, and healthcare operations. You also consent to having been provided with access to a copy of the company's Notice of Privacy Practices.

**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 regarding your protected health information and your patient rights under HIPAA. 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 from the dental office, our website, or by contacting our Privacy Officer:

**Contact:** Jim DeFruscio

**Telephone:** 484-787-2943

**Email:** [privacy@ChildrensDentalHealth.com](mailto:privacy@ChildrensDentalHealth.com)

**Address:** 200 Willowbrook Lane, Suite 220, West Chester, PA 19382

**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 the revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat your child if you revoke this consent.

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 healthcare operations.

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

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

**Relationship to Patient:** \_\_\_\_\_

**Personal Representative's Name:** \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**YOU ARE ENTITLED TO A COPY OF YOUR PAPERWORK AFTER SIGNED.**

**MEDICAL HISTORY**

Child's Physician: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_ Date Last Seen: \_\_\_\_\_

Is your child presently under the care of a physician for any medical issue?  Yes  No

If yes, please describe: \_\_\_\_\_

Is your child currently taking medication?  Yes  No

If yes, please describe: \_\_\_\_\_

Has your child ever been hospitalized for surgery?  Yes  No

If yes, please describe: \_\_\_\_\_

Does your child have allergies to any food or medication?  Yes  No

If yes, please describe: \_\_\_\_\_

Is your child pregnant?  Yes  No

Does your child have a history of:

YES	NO		YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors
<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Speech Problem	<input type="checkbox"/>	<input type="checkbox"/>	Chemo/Radiation Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	<input type="checkbox"/>	Allergy or Sensitivity to Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Drug Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Autism/Asperger's	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems
<input type="checkbox"/>	<input type="checkbox"/>	High Temperature	<input type="checkbox"/>	<input type="checkbox"/>	Fractured Jaw	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ARC/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Blood Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury/Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Liver Involvement	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System Issues	<input type="checkbox"/>	<input type="checkbox"/>	History of Blood Transfusion
<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Birth Defects					If yes, date of transfusion:	
<hr/>											

Is there anything else regarding your child's physical, mental, or emotional health you feel we should know?  Yes  No

If yes, please describe: \_\_\_\_\_

**DENTAL HISTORY**

Dental Practice: \_\_\_\_\_ Dentist Name: \_\_\_\_\_

Date of Last Dental Appointment: \_\_\_\_\_ What was performed:  Cleaning  Other: \_\_\_\_\_

Have you recently been seen by an Orthodontist?  Yes  No

Have you ever had a Consultation with an Orthodontist?  Yes  No

Have you ever had braces?  Yes  No

Please describe the reason(s) for seeking orthodontic treatment?

\_\_\_\_\_

\_\_\_\_\_

Has your child experienced any unfavorable reaction from previous medical or dental care?  Yes  No

If yes, please describe \_\_\_\_\_

**PERMISSION FOR OTHERS TO ESCORT CHILD TO DENTAL APPOINTMENTS**

We understand there may be times when you are unable to attend your child's dental appointment. To help make your visit as prompt and pleasant as possible, please provide the following information:

I, \_\_\_\_\_ hereby give the following individual(s) my permission to bring my child/children to the practice and, in effect, have access to private information about their treatment. I recognize that during the course of the treatment unforeseen circumstances may necessitate additional or different procedures from those discussed. I hereby authorize the listed individual(s) to consent to the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well-being in the professional judgement of the treating provider. I authorize the company and its employees to discuss all dental and medical information with the following individual(s) listed below.

Name of Individual \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Name of Individual \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Name of Individual \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Signature

Printed Name

Date

**CONSENT FOR ORTHODONTIC PRE-TREATMENT EXAMINATION AND  
DISCLOSURE OF POLICY REGARDING PREPARATION OF PRE-TREATMENT RECORDS**

I have been informed that a pre-treatment examination and preparation of orthodontic records are necessary for an orthodontist to make specific recommendations for my care. Pre-treatment orthodontic records include a panoramic x-ray, cephalometric x-ray, facial and intraoral digital photographs, and alginate impressions or an intraoral scan for the creation of study models. I hereby consent to this complete orthodontic examination and to taking any necessary pre-treatment orthodontic records.

I understand that undergoing the pre-treatment examination and the making of pre-treatment orthodontic records does not create a contract or guarantee that CDH Orthodontics, their agents, and employees will provide me with orthodontic treatment. I have been informed that should I decide to go forward with orthodontic treatment, a separate contract will have to be signed.

By signing this document, for treatment planning purposes, I hereby authorize Dentistry for Children Orthodontics and their agents to obtain and share healthcare information verbally, or through written materials, with other healthcare providers. This can include the patient’s dentist, physician or other healthcare providers, and/or any insurance providers and can include any information related to the treatment and care of the patient during their orthodontic treatment.

I certify that I have read and understand the above information. In addition, I certify that, if I am signing on behalf of a minor, I am a parent or guardian of the patient with the legal right to consent for his/her dental care.

**Patient’s Name:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

**Parent or Legal Guardian Name:** \_\_\_\_\_

\_\_\_\_\_  
**Signature**

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

**Witness Name:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Witness**

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