PLEASE PRINT

PERSONAL **PATIENT HISTORY** DATE _____

Child's Name _____ (First / Middle / Last) Nickname (if any) _____

Date of Birth _____ Age ____ Sex: M F School _____ Grade _____

Home Address _____ City _____ State _____ Zip _____

Child's SS # _____ Do you have other children in this practice? _____

Interests or hobbies: _____ Emergency Contact: _____ Phone: _____

Parent's Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Mother's Name _____ Social Security # _____ Home Phone # _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth _____ Occupation _____ Bus. Phone # _____

Employer _____ City _____ State _____ Zip _____

Father's Name _____ Social Security # _____ Home Phone # _____

Mailing Address _____ City _____ State _____ Zip _____

Date of Birth _____ Occupation _____ Bus. Phone # _____

Employer _____ City _____ State _____ Zip _____

Whom May We Thank for Referring You? _____

HEALTH INSURANCE INFORMATION

Dental Coverage ☐

Subscriber (covered employee) _____

Employer providing insurance: _____

Name of insurance carrier (company): _____

Group or Policy # _____

Telephone # (800) _____

Secondary Dental Coverage ☐

Subscriber (covered employee) _____

Employer providing insurance: _____

Name of insurance carrier (company): _____

Group or Policy # _____

Telephone # (800) _____

MEDICAL HISTORY

Child's Physician _____ Address _____ Phone # _____

Date of last physical examination? _____ Results _____

Is a physician treating your child now for a specific illness? ..... Yes No

If so, for what reason? _____

Is your child taking any medication at this time? ..... Yes No

Drug	Dose	Frequency	Reason

Has your child shown any allergies or unusual reactions?

a) Medications or drugs _____

b) Foods _____

c) Other _____

Were there any problems with the birth or pregnancy? ..... Yes No

Did child go home with mother from the hospital? ..... Yes No

Has your child ever been hospitalized? If so, ... Yes No

When? _____

For what reason? _____

Has your child had any operations? If so, ... Yes No

When? _____

For what reason? _____

Are there any psychological or emotional problems you would like to bring to our attention? ..... Yes No

Child's Name _____

Does your child have any history of the following diseases or conditions?

- ☐ Accidents or Severe Infections
- ☐ AIDS or AIDS Related Symptoms, HIV+
- ☐ Anemia or Blood Disorders
- ☐ Asthma or Lung Problems
- ☐ Bleeding Problems
- ☐ Blood Transfusions
- ☐ Cerebral Palsy
- ☐ Convulsion, Seizures, or Epilepsy
- ☐ Diabetes
- ☐ Headaches
- ☐ Heart Murmur, Congenital Heart Disease
- ☐ Hyperactivity
- ☐ Kidney or Bladder Problems
- ☐ Liver Problems, Jaundice or Hepatitis
- ☐ Malignancies
- ☐ Mental Retardation
- ☐ Speech, Learning, or Hearing Disorder
- ☐ Vision Problems
- ☐ Other, if so explain
- ☐
- ☐

PLEASE DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS, PENDING SURGERY, RECENT INJURIES OR ANY OTHER INFORMATION DENTIST SHOULD BE AWARE OR THAT HAS **NOT** BEEN COVERED ABOVE.

_____

DENTAL HISTORY

Why did you make this appointment? _____

_____

Is this your child's first visit to a dentist? Yes No

If not, how long since the last dental visit? _____

Child's previous dentist:

Name _____

Address _____

Approximate date of last dental "x-rays" _____

Has your child ever had any unpleasant dental experience? Yes No

If so, please explain: _____

Does your child have any of the following habits? (indicate ages when occurred)

Bottle to bed at night or nap _____

What was in bottle? _____

Use a pacifier? _____

Thumb or finger sucking _____

Tongue thrusting _____

Lip sucking or biting _____

Mouth breathing _____

Grinds Teeth (Bruxism) _____

Do you feel that your child will cooperate for dental treatment? ..... Yes No

Does your child brush his/her own teeth? ..... Yes No

How frequently and when? _____

Do you brush your child's teeth? ..... Yes No

How frequently and when? _____

Do you or your child use dental floss in cleaning your child's teeth? ..... Yes No

How frequently and when? _____

Has your child had fluoride in any of the following forms?

Fluoride tablets or in multiple vitamins ..... Don't know Yes No

Drinking water (community fluoridation) ..... Don't know Yes No

Topical application on teeth (please circle) Dentist applied, Home rinse, Home brush-on gel, School rinse

Have your child's teeth ever been injured? ..... Yes No

When? _____

Which Teeth? _____

Cause? _____

Were the teeth treated? ..... Yes No

If so describe treatment _____

Does your child have any history of headaches? ..... Yes No

Does your child tend to complain of clicking, popping or crunching noises in his/her ears while chewing? ..... Yes No

Has your child ever had TMJ/TMD problems? ..... Yes No

The signature of a parent or guardian affixed below authorizes the completion of all mutually agreed upon necessary dental services.

Signature _____ Relationship _____ Date _____

SUMMARY: (FOR DOCTOR'S USE) REVIEWER: _____ DATE: _____ Ent by _____

MEDICAL

DENTAL

Raymond E. Broussard, DDS, PA
1724 Grande Blvd. SE, Rio Rancho, NM 87124
(505) 896-0245

Our Office Policies

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. All patients must complete and sign our Registration and Medical/Dental History forms as well as any applicable Consent forms prior to any treatment. We ask that you also sign this after you have read it.

Payment Arrangements:

We accept: **Cash, Checks,** and **Credit Cards** (Mastercard, Visa, Discover, and American Express.) ***There will be a 10% discount given to patients who pay in full for treatment at the time of service using cash or credit card. This discount <u>does not</u> apply to patients whose treatment is billed to insurance by our office.***

Insured patients' deductible plus any copay is due in full at the time of service. Patient's who are seen in the hospital must pay their portion two weeks in advance of service. ***Your account will be charged $25 for checks received for which there are non-sufficient funds. Your account will be charged $27 if you fail to show for an appointment without 24 hour prior notice to our office.***

Treatment Planning:

As a service to our patients, our office provides treatment planning in order to help parents plan and budget for treatment needed on their child. ***Treatment plans are estimates and are subject to change at the time of service.*** A treatment plan is an *estimate* of insurance benefits. If insurance pays less than we estimated, parents are responsible for any remaining balance. Also, treatment may change at the time of service. Parents are responsible for their portion of the original estimate plus any additional costs at the time of service.

Regarding Insurance:

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. Your insurance policy is a contract between you and your insurance company. Although we are happy to assist you with your insurance claims, we are not a party to that contract. In the event we do accept assignment of benefits we require that you pay the deductible (or provide proof that you have done so) and pay the estimated portion of your bill at the time of service. We often accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information.

Minor Patients:

An adult must accompany a minor. No treatment will be performed unless the parent or guardian is present in the office. The adult accompanying a minor, parents or guardians of the minor, are responsible for full payment.

Thank you for reading and signing our policies. Please let us know if you have any questions or concerns.

I have read the policies and I understand and agree to them:

X _____ Date _____

(Signature of Patient or Responsible Party)