Patient ID # ________________ Today's Date __________

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name ______________________________

Nickname ____________________ Sex __________

Birthdate ____________________ Age __________

SS# / SIN ______________________________

School ____________________ Grade __________

Child's Home Address ______________________________

City ______________ State/ Prov. ______ Zip/ P.C. __________

Phone ______________________________

Responsible Party

Name ______________________________

Relationship ______________________________

Address ______________________________

City ______________ State/ Prov. ________ Zip/ P.C. __________

Email ______________________________

Phone ______________ SS#/ SIN ______________

DL# ______________________________

Who is responsible for making appointments?

Name ______________________________

Home Phone ______________ Cell Phone ______________

Work Phone ____________________ Ext. __________

Best time to call ______________________________

Time ______________ Day ______________

____

Mother

☐ Stepmother ☐ Guardian

Name ______________________________

Home Phone ______________ Cell Phone ______________

Work Phone ____________________ Ext. __________

Email ______________________________

Employer ______________________________

Occupation ______________________________

SS#/SIN ______________________________

DL # ______________________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father

☐ Stepfather ☐ Guardian

Name ______________________________

Home Phone ______________ Cell Phone ______________

Work Phone ____________________ Ext. __________

Email ______________________________

Employer ______________________________

Occupation ______________________________

SS#/SIN ______________________________

DL # ______________________________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name ______________________________

Relationship ______________________________

Birthdate ______________ SS#/SIN ______________

Employer ______________ Date Employed __________

Occupation ______________________________

Insurance Company ______________________________

Group # ______________ Employee # __________

Ins. Co. address ______________________________

City ______________ State/ Prov. ______ Zip/ P.C. __________

Deductible ______________ Copay ______________

Amount already used ______________________________

Max. annual benefit ______________________________

Additional Insurance

Insured's Name ______________________________

Relationship ______________________________

Birthdate ______________ SS#/SIN ______________

Employer ______________ Date Employed __________

Occupation ______________________________

Insurance Company ______________________________

Group # ______________ Employee # __________

Ins. Co. address ______________________________

City ______________ State/ Prov. ______ Zip/ P.C. __________

Deductible ______________ Copay ______________

Amount already used ______________________________

Max. annual benefit ______________________________

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check

Credit Card ☐ Visa ☐ MC ☐ Discover ☐ AMEX

☐ I wish to discuss the office's payment policy.

Dental & Health History ***CONFIDENTIAL*** Patient ID # ____________

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? ____________ How often does your child floss? ____________

Is your child's water fluoridated?........ ☐ Yes ☐ No Does your child take fluoride supplements?........ ☐ Yes ☐ No

Does your child:

Suck thumb/finger.................... ☐ Yes ☐ No Chew hard objects (pencils, etc.)............... ☐ Yes ☐ No

Suck/Bite lip......................... ☐ Yes ☐ No Grind teeth .... ☐ Yes ☐ No

Bite/Chew nails .... ☐ Yes ☐ No Clench jaws .... ☐ Yes ☐ No

Previous dentist ____________ Address ____________

Date of last dental visit? ____________

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's physician ____________ Address ____________

Phone # ____________

Previous Hospitalizations/Surgeries/Serious Illnesses? When?

____

____

____

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list)

____

Has your child ever taken FenPhen/Redux? ☐ Yes ☐ No

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐ Yes ☐ No (if yes please describe) ____________

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? ☐ Yes ☐ No

____

Has your child ever had any of the following:

Asthma .... ☐ Yes ☐ No Stomach, liver or kidney problems .... ☐ Yes ☐ No

Cancer............................. ☐ Yes ☐ No Handicaps/Disabilities...................... ☐ Yes ☐ No

Hepatitis .... ☐ Yes ☐ No Tuberculosis .... ☐ Yes ☐ No

HIV/AIDS .... ☐ Yes ☐ No Diabetes .... ☐ Yes ☐ No

Hemophilia......................... ☐ Yes ☐ No Rheumatic Fever .... ☐ Yes ☐ No

A persistent cough or throat clearing Congenital Heart Defect..................... ☐ Yes ☐ No

not associated with a known illness Heart Murmur .... ☐ Yes ☐ No

(lasting more than 3 weeks) .... ☐ Yes ☐ No Convulsions/Epilepsy .... ☐ Yes ☐ No

Abnormal Bleeding.................. ☐ Yes ☐ No Osteoporosis.............................. ☐ Yes ☐ No

Acid Reflux .... ☐ Yes ☐ No

Please explain any medical problem that your child has: ____________

____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist 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 authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. 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 behalf or my dependents.

____________ ____________

Signature of patient (or parent/guardian if minor) Date

Dentist Review

____________ ____________

Signature of Dentist Date

Item 028-1584/40763 PATTERSON OFFICE SUPPLIES 1.800.637.1140

Matthew J Malan DDS

Family & Cosmetic Dentistry

Welcome to our dental office! We are honored that you have selected our dental healthcare team! We take great pride in the dental services we offer our patients. Please review this document carefully. We encourage you to ask any questions you may have about our policies and procedures. Again, thank you for trusting us with your dental care.

1. **CONSENT FOR PROCEDURES**: I consent to the procedures which may be performed during visits at this office including all treatment and services.

2. **ACKNOWLEDGMENT OF RECEIPT**: I acknowledge receiving from Dr. Matthew J Malan the Dental Materials Fact Sheet. Business and Professions code, section 1648.15 requires we provide this fact sheet. It is also available online at our office website.

3. **RELEASE OF INFORMATION**: I authorize the release of information, including diagnosis and records of any treatment or exam rendered to me or my child during the period of such dental care to third party insurance companies or other health practitioners. This information may be sent by mail, phone, email, fax or electronically.

4. **ACKNOWLEDGEMENT OF RECEIPT**: I acknowledge receiving Dr. Matthew J Malan's Notice of Privacy Practices. See Hippa law 45 CFR 164.520. This information is also available online at our office website.

______ Initial

5. **FINANCIAL AGREEMENT**: Payment is due at the time services are rendered. For billing purposes our office may need the following information: drivers license, insurance policy information, billing address, employer information, social security numbers and phone numbers. Please understand billing insurance is a courtesy service and we cannot guarantee payment. As a patient it is important to understand your policy benefits and limitations. <u>If we are billing insurance your estimated patient portion is due at the time of service.</u> There is a $25.00 fee for any check returned from the bank. Patients 18 years of age and older, including those still covered under parents insurance policy, acknowledge being legally responsible for their account. For children of separated parents, financial agreements should be made prior to appointments.

    I authorize payment of my dental benefits to Dr. Matthew J Malan. I understand I am responsible for any amount not covered by my insurance. I understand all financial treatment plans are an *<u>estimation</u>* of what might be owed. I accept full financial responsibility for services rendered on my behalf or my dependents. I assume all fees that may be incurred as a result of collection action, including attorney fees.

______ Initial

6. **CANCELLATION POLICY**: We request that you please notify our office at least 48 hours in advance to cancel or change your appointment. There are many other patients who could use your allotted time. A minimum fee of $35.00 will be applied to accounts if you fail to show or give 48 hours notice. This is not covered by insurance and will be your responsibility to pay prior to your next appointment.

We strive to provide exceptional care and respect to all patients. Our office requires patients to use appropriate conduct towards our staff. Inappropriate behavior may result in dismissal of patient care. Thank you!

____

Print | Sign | Date

If you are a parent/guardian of patients under the age of 18, please indicate your relationship.