Worman & Worman

Pediatric Dentistry

PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

Date__________ Patient Social Security Number__________

Patient's Name __________ Nickname__________

Age _____ Date of Birth _____ Sex____ Race____ School _____ Grade ____

Parents or Responsible Guardian __________ Telephone: Home _______ Cell M _______

Address __________ Cell D_______

Number and Street City State Zip

Name of Child's Physician __________ Date last seen _______

Address __________ Telephone _______

Brothers and Sisters (List by name and age please)

__________ __________

__________ __________

__________ __________

Father's Name __________ Mother's Name__________

Home Address__________

Number and Street City State Zip

Home Phone __________ Former Address __________

Number and Street City State Zip

Father's Occupation __________ SSN__________ Business Phone _______

Name of Employer __________ City _______

Mother's Occupation __________ SSN__________ Business Phone _______

Name of Employer __________ City _______

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

1. Is your child covered by a dental insurance plan? ☐ Yes ☐ No
   Name of parent insured__________ Social Security No. _______
   Name of Insurance __________ Group No. or Policy No. _______
   Has your child received previous dental care under this plan? ☐ Yes ☐ No
2. How did you first hear about our practice? __________
3. Is your child in pain, or have an emergency dental condition? ☐ Yes ☐ No
   If no, reason for bringing child to the dentist at this time __________

HISTORY

	Yes	No
1. Is your child in good health?	☐	☐
If No, what is the reason? __________		
2. Is your child being treated by a physician at this time?	☐	☐
If Yes, why __________		
3. Has your child ever been a patient in a hospital?	☐	☐
If Yes, why __________		
4. Has your child ever received general anesthesia or sedation?	☐	☐
If Yes, why __________		
5. Is your child allergic to anything? (medicine, food)	☐	☐
If Yes, what __________		
6. Is your child taking any medication at this time?	☐	☐
If Yes, what __________	☐	☐
7. Has your child ever had a blood transfusion?	☐	☐
8. Has your child ever been seen by a dentist before?	☐	☐
Date last seen _____ Name of dentist __________		
9. Has your child ever received fluoride in any form?	☐	☐
10. Does your child suck his/her thumb or fingers?	☐	☐
11. Are your child's teeth brushed and flossed once or more a day?	☐	☐
12. Has your child had any unfavorable medical or dental experience?	☐	☐
If Yes, please explain __________		

REVIEWER COMMENTS

ORGAN SYSTEMS

Has this child ever had any treatment of any of the following? Please check Yes or No

Yes	No		Yes	No		Yes	No	
☐	☐	Blood - Circulatory	☐	☐	Gastrointestinal (stomach)	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Hearing	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Tonsils/Adenoids

ILLNESS

Has this child ever been diagnosed as having any of the following conditions? Please check Yes or No and explain below in comments section.

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Eye Problems	☐	☐	Polio
☐	☐	Anemia	☐	☐	Excessive Bleeding Problem	☐	☐	Pregnancy
☐	☐	Allergy	☐	☐	Fainting	☐	☐	Psychiatric Disorder
☐	☐	Arthritis	☐	☐	Hearing Loss	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Scarlet Fever
☐	☐	Autism	☐	☐	Hemophilia	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Hepatitis - Type__________	☐	☐	Sickle Cell Anemia
☐	☐	Bronchitis	☐	☐	HIV	☐	☐	Sinus Problems
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Snoring at Night
☐	☐	Cerebral Palsy	☐	☐	Leukemia	☐	☐	Sore Throats - Frequent
☐	☐	Chicken Pox	☐	☐	Measles	☐	☐	Speech Problems
☐	☐	Cleft Lip/Palate	☐	☐	Mental Retardation	☐	☐	Spina Bifida
☐	☐	Convulsions/Seizures	☐	☐	Mumps	☐	☐	Syndrome______________
☐	☐	Diabetes	☐	☐	Mouth Breathing	☐	☐	Tetanus
☐	☐	Diphtheria	☐	☐	Nutritional Deficiency	☐	☐	Tuberculosis
☐	☐	Drug or Alcohol Abuse	☐	☐	Orthopedic Problems	☐	☐	Tumors
☐	☐	Epilepsy	☐	☐	Pneumonia	☐	☐	Venereal Disease
						☐	☐	Whopping Cough
						☐	☐	Other ______________

Is there anything else that you think we should know about your child? (Disabilities or Handicaps) ____________________

____

I certify that I have read and understand the above questions. I will not hold Dr. Michael Worman, or any member of his staff responsible for any errors or omissions I may have made in the completion of this form.

Because your child is a minor, it is necessary that we have signed permission from a parent/guardian for any and/or all necessary dental services. Your signature below indicates permission granted.

COMMITMENT POLICY

COMMITMENT TO APPOINTMENT POLICY:

We reserve time for each patient in our practice. An appointment put in our schedule with your name in it is a bond of trust that we will be here to serve you and you will be present for that appointment Therefore, our office policy in this regard is extremely firm and inflexible. You must be present for all scheduled appointments. We do no allow cancellations or constant short-notice changes. We charge for all cancellations made less than 48 hours in advance. (We do not accept recorded messages as appointment cancellations or changes). Your signature indicates that we must have mutual respect for each other's time.

COMMITMENT TO FINANCIAL AGREEMENT:

We believe we have a responsibility to use our best professional care, skill and judgment in planning for your dental treatment. Payment is expected at the time services are rendered, unless other financial arrangements were made. We work with all insurance companies to secure benefits. Insurance companies have different benefits available to which you are entitled according to the plan you chose. Should the account become delinquent and turned over to a collection agency, you are responsible for the balance and all collection fees.

______________________	______________________	______________
Signature of Parent/Guardian	Relationship to patient	Date

COMMENTS ____

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Michael A. Worman, D.D.S., P.A.
Sandra A Worman, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, ________________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgment

___ Other (Please Specify)

Worman and Worman Dentistry for Children
Michael A Worman, DDS, PA
Sandra A Worman, DDS

Ph: 727.321.6911
Fx: 727.328.2120

We reserve time for each patient in our practice. Please arrive promptly for all scheduled appointments. Lateness of more than 10 minutes will necessitate a rescheduling of the appointment. All cancellations and rescheduling of appointments requires 48 hours notice. Should you cancel an appointment with less than 48 hours notice, it will constitute a broken appointment and a $50.00 fee will be assessed per child. We adhere strictly to this policy.

All co-pays are due and payable at the time of service, so please be aware of your insurance benefits. Should the account become delinquent and turned over to a collection agency, you are responsible for the balance and all legal and collection fees.

We gladly accept cash, personal checks and all major credit cards for payment. In the event you have a check returned, the return fee is $35.00. The original check amount *plus* the $35.00 fee are then due in the form of a cash payment only. All further appointments will then be cash or credit card only.

Signature:____________________________________

Date:_______________________________________