SHURETT DENTAL GROUP

YOUR CHILD

(Print Please)

PATIENT INFORMATION			
Child's Name:		☐ Male ☐ Female	Date:
Address:			
City:	State: NY	Zip Code:	
Phone #:	Date of Birth:		Social Security #:
School:			Grade:
Who may we thank for referring you to our office?			

MOTHER	FATHER
Name	Name
Home Phone #	Home Phone #
Work Phone #	Work Phone #
Employer's Name	Employer's Name
Social Security #	Social Security #
Date of Birth	Date of Birth

HEALTH HISTORY		
How often does your child brush per day?		
Child's Physician's	Previous Dentist	Date of Last Visit
Is your child's water fluoridated? Yes ☐ No ☐		
List any medications your child is currently taking:		
List any allergies your child has:		
Is your child pregnant? Yes ☐ No ☐	If yes, due date:	
Is your child currently under the care of a physician? Yes ☐ No ☐		
Additional Comments:		

IS YOUR CHILD ALLERGIC TO ANY OF THE FOLLOWING?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain:

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?												
AIDS/HIV Positive	☐Yes	☐No	Cortisone Medicine	☐Yes	☐No	Hemophilia	☐Yes	☐No	Renal Dialysis	☐Yes	☐No	
Alzheimer's Disease	☐Yes	☐No	Diabetes	☐Yes	☐No	Hepatitis A	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No	
Anaphylaxis	☐Yes	☐No	Drug Addiction	☐Yes	☐No	Hepatitis B or C	☐Yes	☐No	Rheumatism	☐Yes	☐No	
Anemia	☐Yes	☐No	Easily Winded	☐Yes	☐No	Herpes	☐Yes	☐No	Scarlet Fever	☐Yes	☐No	
Angina	☐Yes	☐No	Emphysema	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Shingles	☐Yes	☐No	
Arthritis/Gout	☐Yes	☐No	Epilepsy or Seizures	☐Yes	☐No	Hives or Rash	☐Yes	☐No	Sickle Cell Disease	☐Yes	☐No	
Artificial Heart Valve	☐Yes	☐No	Excessive Bleeding	☐Yes	☐No	Hypoglycemia	☐Yes	☐No	Sinus Trouble	☐Yes	☐No	
Artificial Joint	☐Yes	☐No	Excessive Thirst	☐Yes	☐No	Irregular Heartbeat	☐Yes	☐No	Spina Bifida	☐Yes	☐No	
Asthma	☐Yes	☐No	Fainting Spells/Dizziness	☐Yes	☐No	Kidney Problems	☐Yes	☐No	Stomach/Intestinal Disease	☐Yes	☐No	
Blood Disease	☐Yes	☐No	Frequent Cough	☐Yes	☐No	Leukemia	☐Yes	☐No	Stroke	☐Yes	☐No	
Blood Transfusion	☐Yes	☐No	Frequent Diarrhea	☐Yes	☐No	Liver Disease	☐Yes	☐No	Swelling of Limbs	☐Yes	☐No	
Breathing Problem	☐Yes	☐No	Frequent Headaches	☐Yes	☐No	Low Blood Pressure	☐Yes	☐No	Thyroid Disease	☐Yes	☐No	
Bruise Easily	☐Yes	☐No	Genital Herpes	☐Yes	☐No	Lung Disease	☐Yes	☐No	Tonsillitis	☐Yes	☐No	
Cancer	☐Yes	☐No	Glaucoma	☐Yes	☐No	Mitral Valve Prolapse	☐Yes	☐No	Tuberculosis	☐Yes	☐No	
Chemotherapy	☐Yes	☐No	Hay Fever	☐Yes	☐No	Pain in Jaw Joints	☐Yes	☐No	Tumors or Growths	☐Yes	☐No	
Chest Pains	☐Yes	☐No	Heart Attack/Failure	☐Yes	☐No	Parathyroid Disease	☐Yes	☐No	Ulcers	☐Yes	☐No	
Cold Sores/Fever Blister	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Psychiatric Care	☐Yes	☐No	Venereal Disease	☐Yes	☐No	
Congenital Heart Disorder	☐Yes	☐No	Heart Pace Maker	☐Yes	☐No	Radiation Treatments	☐Yes	☐No	Yellow Jaundice	☐Yes	☐No	
Convulsions	☐Yes	☐No	Heart Trouble/Disease	☐Yes	☐No	Recent Weight Loss	☐Yes	☐No				

Have you ever had any serious illness not listed above? ☐Yes ☐No If yes, please explain:
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DENTAL INSURANCE INFORMATION			
Insurance Company:			Phone #:
Address:			Group #:
City:	State:	Zip Code:	
Insured's Name:			Birth Date
Insured's Employer:			
Employer's Address:			Social Security #
City: New York	State:	Zip Code:	

In addition to most private insurance, WorkPlace Dental accepts American Express, Discover, MasterCard & Visa credit cards, as well as cash. Some employers offer payroll deduction. Ask your Human Resources Department for details.

Agreement and Authorization

I understand that keeping appointments is very important. If I cannot make an appointment, for any reason, I must give at 24 hours' notice. Failure to provide 24 hours' notice for a missed appointment may prevent me from being able to reserve future appointments in advance.

I understand that my health insurance carrier may pay less than the actual bill for services rendered on my behalf and my dependents, and that I am responsible for the difference. If I do not pay my entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in Shurett Dental Group being unable to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees (usually 40% of the amount owed) incurred in attempting to collect on this account balance.

I certify that that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I give Shurett Dental Group permission to perform dental treatments on me/my child, which may include anesthesia for the patient's comfort. I authorize Shurett Dental Group to leave messages on my home answering machine or cell phone voice mail concerning appointment times, scheduled treatment including premedication reminders, and payment information.

I authorize Shurett Dental Group to use or disclose any necessary patient health information (PHI) in order to carry out treatment, payment activities, and healthcare operations, as fully described in our Notice of Privacy Practices. I understand that upon request I will receive a copy of the Notice of Privacy Policies as prescribed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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Signature of Patient (or parent if a minor) Today's Date