LEFCOE, WEINSTEIN, SACHS, SCHIFF & ASSOCIATES
FAMILY DENTISTRY

PERSONAL, MEDICAL AND DENTAL HISTORY

We are continually concerned with your health and the care that is rendered to you. It is therefore important to update this information on a yearly basis. If you have any questions, please feel free to ask one of our staff members to assist you. Please print clearly.

PATIENT INFORMATION

Date _____

Name of Minor/Child _____
First M.I. Last

Sex: ___ M ___ F Age_____ Birthdate_____ Nickname_____

Home Address _____
Street City State Zip

Child's S.S. #_____ Whom may we thank for referring you? _____

RESPONSIBLE PARTIES / INSURANCE INFORMATION

Father's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone_____ Work Phone_____

Cell Phone _____

Employer _____
RANK/RATE

Employer Address _____
How long employed

City, State, Zip_____

Union or Local _____

S.S.#_____ **BIRTHDATE** _____

Do you have dental insurance coverage for minor/child? ___Yes___No

Insurance Co. _____

Group #_____ Policy ID # _____

Ins. Co. Address _____

City, State, Zip_____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone_____ Work Phone_____

Cell Phone _____

Employer _____
RANK/RATE

Employer Address _____
How long employed

City, State, Zip_____

Union or Local _____

S.S.#_____ **BIRTHDATE** _____

Do you have dental insurance coverage for minor/child? ___Yes___No

Insurance Co. _____

Group #_____ Policy ID # _____

Ins. Co. Address _____

City, State, Zip_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household, a relative or friend.)

Name_____ Relationship _____

Address _____
Street City State Zip

Home Phone_____ Work Phone _____

AUTHORIZATION

I authorize the following person(s) to bring my child in for appointments and approve doctor recommended treatment.
I also give this practice my permission to release the doctor's recommended future treatment to said authorized person(s):

Name _____ #_____

Name _____ #_____

Name _____ #_____

I, _____ , have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that by signing this section, I am giving my consent to your use and disclosure of my child's PHI to carry out treatment, payment activities and health care operations.

Signature: _____

DENTAL/MEDICAL HEALTH HISTORY (Confidential)

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.

Patient ID # _____

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
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew hard objects (pencils, etc.)	☐ Yes	☐ No
Grind teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of last dental visit _____

Previous Dentist _____

Address _____

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

Has your child ever had any of the following:

Asthma	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses — When?

_____ _____

_____ _____

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

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.)? _____

Please explain any medical problems that your child has: _____

_____

FINANCIAL ARRANGEMENTS: Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment:

○ Cash ○ Personal Check ○ Charge Cards

I hereby apply for treatment by the above dentists, their associates and/or assistants. Treatment may include x-rays, injections and/or such other office procedures they deem necessary.

If health care workers are accidently exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Payment policies of Drs. Lefcoe, Weinstein, Sachs and Schiff have been explained to me, and I hereby acknowledge and accept responsiblity for payment of all charges incurred with the above dentists, acknowledging that they may obtain a credit report in order to establish credit.

It is understood that this responsibility extends to the total charges without regard to possible insurance benefits, and that any insurance benefits which may be provided will be considered part of my financial resource only and will not waive my responsibility. If payment for such medical services is not made when due, the undersigned agrees to pay all costs of collecting the medical bill, including 33 1/3% attorneys' fees and costs, skip tracing and third party services. I have read and fully understand the meaning and consequences of the above statement. INTEREST RATE: 1½% PER MONTH (Equivalent 18% APR) on that part of accounts due over 60 days (Minimum interest rate $.50).

PATIENTS WITHOUT INSURANCE - PAYMENT IS DUE AT THE TIME OF THE VISIT

A charge of $25.00 will be made for appointments broken or cancelled without 24 hour notice. A charge of $25.00 will be made for returned checks.

PATIENT_____**RESPONSIBLE PARTY** _____

DATE_____