# GREGORY D. EVANS, DDS PC

3221 Eastbrook Drive; Fort Collins, CO 80525 ~ Phone: (970) 407-1020 Fax: (970) 266-8238

## HEALTH HISTORY

We believe that to best serve your child's dental health, we must understand your child in the larger context of his/her social and medical history. Please help us by thoughtfully answering the following questions. Please note that all health histories are held in strict confidence among our team. Complete both pages of the form.

_____ ○M / F○ _____ _____ _____

Child's Name (Last, First) | Child's Nickname | Date of Birth | Weight

Child's Physician _____Phone_____ Family Dentist_____

Physician's Address_____

Is the child under care for any medical conditions? ( Y○/○N ) Medical diagnosis? _____

Immunizations up to date? ○Y ○N ○Unsure) Medication taken by child? _____

Has child ever spent the night in a hospital? Explain:_____

**Allergies:** Latex ○Y ○N ) Metal ○Y ○N ) Foods: _____

Medications: _____

Reaction to above allergies: _____

Has your child ever had or been diagnosed with any of the following:

| (Y) | (N) | | (Y) | (N) | |
|---|---|---|---|---|---|
| ○ | ○ | Anemia | ○ | ○ | Aids/HIV |
| ○ | ○ | Blood Disease | ○ | ○ | Cancer or Malignancy |
| ○ | ○ | Blood Transfusions | ○ | ○ | Chronic Illness |
| ○ | ○ | Bruises Easily | ○ | ○ | Diabetes |
| ○ | ○ | Hemophilia | ○ | ○ | Epilepsy |
| ○ | ○ | Sickle Cell Trait or Disease | ○ | ○ | Hepatitis/Liver disease |
| | | | ○ | ○ | Kidney Disease |
| | | | ○ | ○ | Transplant_____ |

| (Y) | (N) | | (Y) | (N) | |
|---|---|---|---|---|---|
| ○ | ○ | Asthma | ○ | ○ | Birth Defects |
| ○ | ○ | Respiratory Problems | ○ | ○ | Child Abuse |
| | | Disease/RSV | ○ | ○ | Concussion |
| ○ | ○ | Heart Surgery | ○ | ○ | Growth Problems |
| ○ | ○ | Heart Murmur/Defect | ○ | ○ | Premature Birth |
| ○ | ○ | High Blood Pressure | ○ | ○ | Surgery _____ |
| ○ | ○ | Rheumatic Fever | ○ | ○ | Syndrome _____ |

| (Y) | (N) | | (Y) | (N) | |
|---|---|---|---|---|---|
| ○ | ○ | Arthritis | ○ | ○ | Brain Injury |
| ○ | ○ | Bone/Joint Problem TMJ | ○ | ○ | Developmental Delays |
| ○ | ○ | Headaches | ○ | ○ | Hearing and/or Speech Problems |
| ○ | ○ | Metabolic Disorder | ○ | ○ | Hyperactivity/ADD/ADHD |
| ○ | ○ | Muscle Disorder | ○ | ○ | Neurological Disorder |

Dentist's Notes

HEALTH HISTORY REVIEWED
- o No Concerns
- o Medical Alert
- o Allergy _____
- o PreMed _____
- o Call MD _____

Doctor's Initials _____

Are there any other conditions we need to know?_____

Has your child ever had traumatic injury to the head?_____

Has your child ever had traumatic injury to the teeth?_____

**Health History – Page 2**

Please answer based upon your child's age**:**

1. Feeding History (ages 0 – 2.5 years):
   My child was: ◯ breast fed ◯ bottle fed ◯ combination
   Bottle introduced at age: _____
   Bottle Use: ◯ currently used ◯ discontinued (At what age? ____)

2. Oral Hygiene (ages 0 – 9 years):
   Have your ever received instruction on how to clean your child's teeth? ◯ yes, ◯ no
   My child brushes ____times a day. An adult ( ◯ supervises, ◯ helps, ◯ brushes, ◯ none) per day.
   My child has their teeth flossed ( ◯ every day, ◯ occasionally, ◯ not currently).

3. Fluoride Use (all ages):
   When did your child begin to use toothpaste? _____ How often / day? _____
   Who applies the toothpaste to the brush? ☐ child, ☐ adult
   My child ( ◯ does, ◯ did, ◯ did not) receive supplemental fluoride drops or tablets.
   Our primary water supply (◯ does, ◯ does not, ◯ unsure) contain fluoride.

4. Habits (all ages):
   My child ( ◯ does, ◯ does not) suck a ( ◯ thumb, ◯ finger, ◯ pacifier).
   When, where and how often? _____Stopped at age: _____

5. Dental History (all ages):
   Is there any history in your family of any:
   ☐ malocclusions (bad bites), ☐ missing teeth, ☐ extra teeth, ☐ other(explain_____

   Do you think there is anything wrong with your child's teeth? _____
   Has your child ever had a ☐ space maintainer, ☐ retainer, ☐ braces, ☐ or any other orthodontic treatment? (Explain: _____)
   What is the primary reason for today's visit? _____

6. Family History (all ages):
   Do mother and father live together? ◯ yes, ◯ no
   Is your child adopted? ◯ yes, ◯ no If yes, when? _____
   Please explain any recent family status changes (divorce, separation, death, etc.), and note when your child experienced this change: _____
   Is your child receiving any therapy or extra help in any area? _____

7. Referral (all ages):
   How did you hear about our office? (List name or media responsible for referral): _____

**CONSENT**

It is necessary, because your child is a minor, for permission to be obtained from a parent/legal guardian before necessary treatment is performed. The signature of the parent/guardian below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment, regardless of insurance coverage.

Signed: _____ Date: _____

Also, the undersigned consents to the use of agreed upon x-rays and clinical photographs. My signature also indicates that I give permission to use my child's photograph for in office monitors. Any photograph taken will not be used for marketing or advertisements. The subject of the photograph will not be identified by name, nor will any financial reimbursement be paid for the photograph. I fully understand this consent and have no further questions.

Signed: _____ Date: _____

# GREGORY D. EVANS, DDS PC

We find that our clients appreciate knowing in advance what is expected of them financially and what terms and conditions are available. If you have any questions, please direct them to one of our Financial Administrators.

As a condition of treatment by this office, all fees are due and payable at the time of service. We gladly accept cash, personal checks, and most major credit cards for payment of your account. For your convenience, we also work with Care Credit.

As a courtesy to you, we will submit your claim for you if you have insurance. Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. You are responsible for the total charges or any difference remaining following payment by your insurance company. We will estimate as closely as possible your coverage. If your insurance has not made payment or you feel that your insurance company has not made adequate payment on your account, you must contact them first to discuss this matter.
_____ (initial)

Your insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within 30 days. We guarantee accurate filing based on the information that you provide to us. On day 31, if your insurance company has not reimbursed our office, we will investigate the delay as a courtesy. If needed, we will resubmit your insurance claim one time for you. We will notify you of your insurance company response and the responsibility of the balance will revert to you.
_____ (initial)

Payment is expected on date of service. We will try to accurately estimate your patient portion which is due after insurance. As a courtesy, we would be happy to send a pre-determination to assist with accurate patient portions. In different circumstances, if the patient portion was not collected on date of service, payment is expected within 30 days of insurance payment. We will send you a statement, and payment is due upon receipt. We will begin to charge a late fee of $5.00 per month on accounts that have remaining balances over 90 days. For your convenience you may now pay your bill online at gobiggrins.com and click on “Payment Portal”. Big Grins is proud to be an on time dental practice. When we schedule an appointment for your child, two events occur. 1. We will hold that appointment time for your child in our appointment book and 2. We trust that you will arrive on time for that appointment. If you are late for an appointment, we will try to do our best to fit you in our schedule. However, it may be necessary for us to reschedule your appointment. Please note that there will be a $25 fee for cancellations made with less than a 24 hours notice.

In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services; and I agree to pay all legal costs including collection fees and attorney fees if I fail to pay my account. I grant you, or your assigned, to telephone me at home or at my work to discuss matters related to this form. I have read and agree to the above conditions of treatment.

_____ _____

Signature Date

_____

PLEASE PRINT name of Parent/Guardian

Gregory D Evans, DDS PC 3221 Eastbrook Drive Fort Collins, CO 80525 970-407-1020

**1. Tell Us About Your Child**

Child's Name

_____
Last First Date of Birth

Siblings:

_____
Last First Date of Birth

_____
Last First Date of Birth

_____
Last First Date of Birth

Child's Main Phone #_____

Child's Home Address_____

_____

**2. Parent's Information**

Name:_____

Parent ○ StepParent ○ Guardian ○

Date of Birth:___/___/____

Employer_____

Work #_____

Home #_____

Cell Phone #_____

SS#_____

Email_____

**3. Parent's Information**

Name:_____

Parent ○ StepParent ○ Guardian ○

Date of Birth:___/___/____

Employer_____

Work#_____

Home #_____

Cell phone#_____

SS#_____

Email_____

**Do Parent's live together?** Yes ○ No ○

**4. Who is Accompanying the Child Today?**

Name_____

Relationship_____

Do you have legal custody of this child? ○ Yes ○ No

**5. Primary Dental Insurance**

Insurance Co. Name_____

Insurance Co. Address_____

_____

Insurance Co Phone #_____

Group #_____

Member ID_____

Subscribers Name_____

Relationship to Patient_____

Subscriber's Date of Birth:___/____/_____

Subscriber's SSN_____

Subscriber's Employer_____

**6. Do you have secondary dental insurance?**

No ○ Yes ○

If yes, you will be asked to provide us with this additional information.

We are happy to file your insurance claims as a courtesy to you. Thank you for providing accurate and updated information as it will expedite timeliness on your account.

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# Notice of Patient Health Insurance Portability and Accountability Act (HIPAA)

**Patient Name:_____Date of Birth: _____**

**I have read or had the opportunity to read practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:**

- **A statement that this practice is required by law to maintain the privacy of protected health information.**
- **A statement that this practice is required to abide by the terms of the notice currently in effect.**
- **Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.**
- **A description of each of the other purposes for which this practices I permitted or required.**
- **A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.**
- **My individual rights with respect to protect health information and a brief description of how I may exercise these rights in relation to:**

  - ☐ **The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.**
  - ☐ **The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.**
  - ☐ **The right to receive confidential communications of protected health information.**
  - ☐ **The right to inspect and copy protected health information.**
  - ☐ **The right to amend protected health information.**
  - ☐ **The right to receive an accounting of disclosures of protected health information.**
  - ☐ **The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.**

**This practice reserves all rights to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.**

**SIGNATURE_____ DATE_____**

**Relationship to patient (if signed by a personal representative of patient)_____**