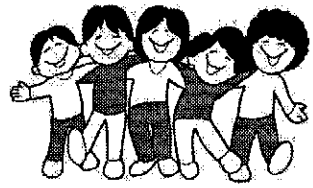
Jennifer K. Hoppe, DDS



Pediatric Dentistry

General Information

Child's Name_____ Date of Birth:_____ Age:_____

Child's Social Sec.#:_____ Siblings (Names and Ages):_____

Home Address_____
Street Apt. # City State Zip

Home Phone:_____ Preferred Name/Nickname:_____

Mother's or Guardian's Name:_____ Birthdate:_____ Social Sec.#:_____

Home Address (if different from above):_____
Street Apt. # City State Zip

Phone:_____

Mother's Employer:_____ Occupation_____

Employer's Address:_____

Work Phone:_____ Alternate Number (e.g. cell, pager):_____

Father's or Guardian's Name:_____ Birthdate:_____ Social Sec.#:_____

Home Address (if different from above):_____
Street Apt. # City State Zip

Phone:_____

Father's Employer:_____ Occupation:_____

Employer's Address:_____

Work Phone:_____ Alternate Number (e.g. cell, pager):_____

Primary Dental Insurance Information

Name of Insured:_____ Is insured a patient? Yes No

Insured's Birthdate_____ SSN#:_____ Group #:_____

Insured's Address:_____
Street Apt. # City State Zip

Insured's Employer Name:_____

Insured's Employer's Address:_____
Street Apt. # City State Zip

Dental Insurance Company: _____ Phone:_____

Insurance Co. Address:_____

Referral Information

Whom may we thank for referring you to our practice?_____

Please circle one or more if applicable: Relative Another Patient Yellow Pages

Dental Office Physician Newspaper School Work Website Other_____

Medical History

Name of Physician/Pediatrician:_____
Phone:_____

Date of last exam:_____ Are your child's immunizations current? Yes No

Is your child in generally good health? Yes No If no, please explain:_____

_____

Is your child currently taking any medications, herbs, or supplements (vitamins)?_____

Has your chid ever had any history of problems with the following?

Developmental Delay	Yes	No	Asthma	Yes	No
Bleeding Problems/Blood Disorders	Yes	No	Frequent ear/throat infections	Yes	No
Speech Delay/Hearing Difficulty	Yes	No	Seizures/Epilepsy	Yes	No
Frequent Fevers	Yes	No	Allergies Yes_____		No
Frequent Headaches	Yes	No	Heart Problems	Yes	No
Radiation Treatment	Yes	No	Liver Problems/Hepatitis	Yes	No
Tuberculosis	Yes	No	Adverse reaction to drugs Yes_____		No
Kidney Problems	Yes	No	Diabetes	Yes	No
Thyroid Problems	Yes	No	Cancer	Yes	No
Cerebral Palsy	Yes	No	Sinus Problems	Yes	No
Rheumatic Fever	Yes	No	Heart Murmur	Yes	No
Immune System Problems	Yes	No	Anemia	Yes	No
Tumors/Growths	Yes	No	Stomach Problems	Yes	No
Mental/Nervous Disorders	Yes	No	Respiratory/Breathing Problems	Yes	No
Pregnancy	Yes	No	Sleep Apnea	Yes	No
Due Date _____			Behavioral Problems	Yes	No
Arthritis	Yes	No	Hay Fever	Yes	No
Head Injuries	Yes	No	Jaundice	Yes	No
Leukemia	Yes	No			

Any other problems not listed above?_____

Has your child ever had a blood transfusion? Yes No If yes, under what circumstances?_____

_____

Was your child born premature or have any complications at birth? Yes No If yes, please explain:

_____

Has your child ever been to the emergency room or been hospitalized? Yes No If yes, please explain:

_____

Dental History

Last visit to the dentist (date):_____ Dentist's Name:_____

Has your child complained about dental problems? Yes No If yes, please explain:_____

_____

History of injury to mouth, teeth, head? Yes No If yes, please explain:_____

_____

Has your child ever had complications following dental treatment? Yes No If yes, please explain:

_____

Is there a family history of "soft teeth" or "bad teeth"? Yes No If yes, please explain:_____

_____

Has your child had a history of any of the following? (circle all that apply)

Thumbsucking Fingersucking Lip Biting Nail Biting Pacifier Use

Missing Teeth Extra Teeth Tongue/Lip Piercings Grind Teeth

Is your child currently breast feeding, bottlefeeding, or using a "sippy cup" during the day/night? Yes No

If no, age your child stopped breast feeding?_____ Bottle feeding?_____

Does your child brush teeth daily? Yes No Number of brushings?_____ Floss daily? Yes No

Do you (parent or other adult) assist your child with tooth brushing? Yes No Flossing? Yes No

Is fluoride taken in any form (toothpaste, vitamins, supplements, etc.)? Yes No If yes, explain:

_____

Purpose of today's dental visit? _____

Do you expect your child to cooperate for examination, cleaning, dental treatment? Yes No

If no, please explain:_____

Is there anything you would like to discuss with the Doctor?_____

_____

_____

_____ Date:_____

Signature of parent/guardian completing form

Consent for Treatment

State law requires us to obtain your written consent for dental treatment or surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.

I hereby authorize Jennifer K. Hoppe, DDS, assisted by other dentists, and / or dental auxiliaries of her choice to perform upon my child or legal ward dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids.

In general terms the dental procedure(s) or operation may include:

A. Examination, cleaning of teeth and application of topical fluoride.
B. Application of plastic "sealants" to the grooves of the teeth.
C. Treatment of diseased (decayed) of injured teeth with dental restorations (fillings or crowns).
D. Treatment of diseased or injured oral tissues (hard and/or soft), including nerve treatment(s).
E. Removal (extraction) of one or more teeth.
F. Replacement of missing teeth with dental problems.
G. Treatment of malposed (crooked) teeth and/or oral development and growth abnormalities.
H. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures.
I. Use of sedative drugs to control pain, gagging, apprehension and/or disruptive behavior.
J. Use of general anesthesia to accomplish the necessary treatment.
K. Other _____

I understand that although good results are expected, the possibility and nature of complications cannot be accurately anticipated and therefore, no guarantee is expressed or implied either as to result of the treatment or as a cure. I further authorize the doctor to perform other dental service(s) that in her judgement are advisable for my child or legal ward, with the exception of (if NONE, state so):
NONE_____

Although their occurrence is extremely rare, some risks have been reported to be associated with dental or oral surgery procedures. State law requires us to mention the possible risk of numbness, infection, swelling, bleeding, bruising, discoloration, nausea, vomiting, allergic or drug reactions, brain damage, stroke, heart attack, aspiration or swallowing of a foreign object, or scars associated with such procedures. I further understand and accept that complications may require hospitalization and may even result in death in rare cases.

I hereby state that I have read and understand this consent, and that all questions I have were answered to my satisfaction. I understand I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

Patients who carry dental insurance need to understand that all dental services will be charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I agree that I am personally responsible for all dental treatment I receive and that I have a right to an estimate before any dental treatment begins.

_____ Date:_____

Signature of patient

_____ Date:_____

Signature of guarantor of payment/responsible party

Relationship to Patient:_____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

By signing below I acknowledge awareness of office Privacy Practices which are posted at the front desk and are available to me at my request.

_____

Please Print Name

_____

Signature

_____

Date