Hello!

LAYTON
FAMILY DENTAL

Thank you for selecting our dental healthcare team to care for your child's dental needs! We will strive to provide your child with the best possible Dental Care! Please fill out these forms completely so we can understand your child and their needs better.

Patient Information
(Confidential)

Child's Name_____Nickname_____DOB_____
School Now Attending_____Grade_____Age_____Male/Female
Father's full name, address and phone#_____
Mother's full name, address and phone#_____
Father employed by:_____Business phone_____
Mother employed by:_____Business phone_____
Child lives with: Mother_____ Father_____Guardian_____

Responsible Party

Name of person responsible for this Account_____
Address_____Phone_____Relationship to patient _____
Is this person a patient here at our office?_____

Insurance Information

Name of subscriber_____Relationship to patient_____
Date of Birth _____ SSN/Member ID_____
Name of Employer _____Work Phone _____
Business Address _____City_____State_____ Zip _____
Insurance Company _____Effective date_____Group #_____
Insurance Company Website_____Contact phone Number_____
Other family members that also have this insurance:_____

_____

***Does your child have any additional insurance? Yes _____ No _____

If Yes please ask for additional insurance form.

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Health history for Children under age 18

Is your child presently under the care of a physician? Yes ☐ No ☐ If yes, for what condition?

_____

Has your child ever been hospitalized? Yes ☐ No ☐ If yes, for what reason:_____

Is your child presently taking any medications? Yes ☐ No ☐ If yes, please list:_____

_____

Are immunizations up to date? Yes ☐ No ☐ Last Tetanus shot or booster:_____

Is there a family history of any of the following:

Bleeding Disorder Yes ☐ No ☐ **Diabetes** Yes ☐ No ☐ **Missing Teeth** Yes ☐ No ☐

Heart Disease Yes ☐ No ☐ **Hepatitis** Yes ☐ No ☐ **Latex Allergy** Yes ☐ No ☐

Has your child had a history of any of the following:

	YES	NO		YES	NO
Anemia or blood disorder	☐	☐	Convulsions or Seizures	☐	☐
Asthma	☐	☐	Ear Infections	☐	☐
Birth Defects	☐	☐	Diabetes Type 1	☐	☐
Bleeding Disorder	☐	☐	Diabetes Type 2	☐	☐
Breathing Difficulty	☐	☐	Frequent Ear Infections	☐	☐
Broken Bones	☐	☐	Epilepsy	☐	☐
Cerebral Palsy	☐	☐	Fainting or dizziness	☐	☐
Chicken Pox	☐	☐	Hearing Problems	☐	☐
Cleft Lip or Palate	☐	☐	Heart defect or murmur	☐	☐
Emotional or behavior Problems	☐	☐	Hepatitis/Liver Disorder	☐	☐
Kidney Disease	☐	☐	Lung Disease	☐	☐
Measles/Mumps	☐	☐	Mononucleosis	☐	☐
Nervous Condition	☐	☐	Neurological Disorder	☐	☐
Rheumatic Fever	☐	☐	Thyroid Disorder	☐	☐
Vision Problems	☐	☐	Whooping Cough	☐	☐

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Dental Health Habits and History

(Children age 17 and under)

Name of last dentist:_____Why is your child here today?_____
Date of last dental cleaning:_____What was done during that visit?_____

Is your child having any discomfort/pain? Yes ☐ No ☐ Please describe:_____

_____

Has your child ever had any unfavorable dental experiences? Yes ☐ No ☐
Please describe:_____

Has your child ever had any injuries to their mouth-teeth or head? Yes ☐ No ☐ Date:_____
Please Describe incident:_____

Is your water supply fluoridated? Yes ☐ No ☐ Is dental floss used daily? Yes ☐ No ☐

Does your child take fluoride supplements? Yes ☐ No ☐ Name of Fluoride:_____

Does your child brush his/her own teeth? Yes ☐ No ☐ If so, how often? _____
If not who helps?_____ How often?_____

Did your child ever sleep with a bottle? Yes ☐ No ☐ What did it contain?_____

Has anyone recommended that your child see and orthodontist for braces? Yes ☐ No ☐

Is there any known allergy to ***foods***? Yes ☐ No ☐ If yes please list:_____

_____

Does your child have any of the following oral habits?

Thumb sucking	Yes ☐ No ☐
Finger sucking	Yes ☐ No ☐
Nail Biting	Yes ☐ No ☐
Mouth Breather	Yes ☐ No ☐
Lip Sucking	Yes ☐ No ☐
Pacifier	Yes ☐ No ☐
Grinding of teeth	Yes ☐ No ☐
Excessive Gum Chewing	Yes ☐ No ☐
Tobacco in any form	Yes ☐ No ☐

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline
☐	☐	Sulfa

Other _____

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Cancellation & Broken Appointment Policy

It is to the benefit of all our patients and our staff to know when someone is unable to attend their scheduled appointment. When you make an appointment, we will consider it a verbal contract between us. We will attempt to confirm your appointment 2 days prior to your scheduled time. For appointments that are scheduled for 2 hours or more we may request a call back for confirmation.

We do require at least **2 full days** notice to cancel or change your appointment, this will allow adequate time to schedule another patient in your appointment slot.
Any broken or failed appointment without the requested 2 Full Day notice will be charged a fee of $25. **Longer appointment times may be charged a per hour fee.

Thank you for your acknowledgment and consideration.

Dr. Aaron Layton DDS

I Have Received notice of Layton Family Dental's policy for Cancellation and Broken appointments.

Print your name_____

Patient Signature _____Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices. (HIPPA)

*** You may refuse to sign this Acknowledgment

I,_____, Have received a copy of this office's Notice of Privacy Practices.

_____

Please Print the Name of your dependent or dependents that are under age 18

_____

Signature of Parent or Guardian

_____

Date

_____

For office use only

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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

☐ An emergency situation prevented us from obtaining acknowledgment

☐ Other (please specify)

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law. (August 14, 2002)

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Financial Policy and Payment Options

Layton Family Dental strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. At the onset of treatment, we will provide you with an **estimate** of your total costs. Please understand that this will only be an **estimate**. If the need for additional treatment arises during the course of the original treatment plan the fees could change. *Be assured that we will notify you of fee changes and obtain your approval prior to proceeding with treatment.*

Our primary goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to to bill your dental insurance on your behalf. Please remember that the contract itemizing your dental benefits is between you, your employer and your insurance carrier. We only bill your insurance as a convenience for you. **Regardless of coverage, your estimated co-payment is due in full the day of treatment.** Any insurance claim not paid in full after 60 days will become your responsibility. Should the insurance pay at a later date then you will receive a refund check. Also remember that dental insurance plans are not designed to cover all of your dental expenses.

We accept most major credit cards, as well as checks and cash. We are also pleased to offer our patients an extended monthly payment plan option through a dental financing company. **CareCredit.** is able to extend credit for up to **6 months at 0% interest.** This must be arranged prior to receiving any treatment. Please ask our patient coordinator for an application or more details and a brochure with instructions on how to apply.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me and/or my child during the period of such dental care to a third party payer and/or health practitioners. I authorize and request that my insurance company pay directly to the dentist and/or dental group insurance benefits otherwise payable to me.

Furthermore, I accept full financial responsibility for this account and for all dentistry performed upon me and my dependents in this dental office. I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits. I also understand that this office cannot guarantee my insurance status in these areas. Any insurance estimate or information given to me by this office is not a guarantee of of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay at that time. **Any balance on my account after 60 days will accrue a 1.5% per month finance charge.**

Patient Printed name_____**Date:**_____

Signature of Parent or Guardian_____**Relationship to pt.**_____