Confidential Child Medical History

Please Print

First Name MI Last Name Nickname			Today's Date
Address			Date of Birth (required)
City State		Zip	
Home Phone Parent's Cell Phone			Sex M F
Physician Name Address		Physician Phone	
Pharmacy Name Address		Pharmacy Phone	Your Email Address
Name and Address of person we can contact in case of emergency (other than your family home)			Phone
How did you hear about us?		Other family members seen here:	

Please Circle Y (yes) or N (no) – Do Not Leave Any Areas Blank

Abnormal Bleeding	Y N	Heart Surgery	Y N	Seizures	Y N
Allergies	Y N	Hemophilia	Y N	Sickle Cell Disease	Y N
Anemia (Low Iron)	Y N	Hepatitis A or B	Y N	Sinus Problems	Y N
Arthritis	Y N	High Blood Pressure	Y N	Sleep Apnea (Snoring)	Y N
Artificial Joints	Y N	HIV or AIDS	Y N	Stroke	Y N
Artificial Heart Valve	Y N	Hyperactivity	Y N	Thyroid Problems	Y N
Asthma	Y N	Hyponasal Voice	Y N	Tuberculosis	Y N
Bed Wetting	Y N	Kidney Problems	Y N	Ulcers	Y N
Blood Transfusion	Y N	Liver Disease or Hepatitis C	Y N	Upper Airway Infections	Y N
Cancer/Chemo/Radiation	Y N	Low Blood Pressure	Y N	Yellow Jaundice	Y N
Chronic Nose Running	Y N	Mitral Valve Prolapse	Y N	**ALLERGIES**	
Colitis (Irritable Bowel)	Y N	Nightmares	Y N	Aspirin	Y N
Congenital Heart Defect	Y N	Night Terrors	Y N	Codeine	Y N
Developmental Delays	Y N	Nocturnal Mouth Breathing	Y N	Dental Anesthetics	Y N
Diabetes	Y N	Noisy Breathers	Y N	Erythromycin	Y N
Earaches	Y N	Pace Maker	Y N	Jewelry	Y N
Epilepsy	Y N	Poor Concentration	Y N	Latex	Y N
Fainting Spells	Y N	Psychiatric Problems	Y N	Metals	Y N
Fever Blisters	Y N	Obesity	Y N	Penicillin	Y N
Headaches	Y N	Restless Sleep	Y N	Tetracycline	Y N
Heart Attack	Y N	Rheumatic Fever	Y N	Other:	

List any medications including herbals and vitamins:_____
_____
_____

Signature_____ **Date**_____

Child Dental Questionnaire

For us to get to know the children better and develop a trusting relationship with them, we request that parents remain in the reception area during all visits. Sedation dentistry is available for ages 18 and older. Children would be referred to a special dentist for sedation.

1. What is your chief dental concern for your child? _____
2. When was your child's last dental exam and cleaning? _____
3. Does your child have any toothaches? ***Yes – No***
   Is there a bump on the gum? ***Yes – No***
   If any, list pain medications given to child. _____
4. How often does your child brush? _____ Do you help them brush?_____
   Is the brush? ***Soft - Medium - Hard***
5. Are crooked teeth a concern? ***Yes – No***
   For whom? ***Child - Parent***
6. Is your child a big milk drinker? ***Yes – No***
7. How many cups of juice a day? _____
8. How many cups of soda a day _____
9. How many hours of gum chewing a day?_____
10. Does your child grind their teeth at night? ***Yes – No***
11. Is your child a noisy eater? ***Yes – No***
12. Does your child get frequent sinus or ear infections? ***Yes – No***
13. Does your child take afternoon naps? ***Yes – No- Not Applicable***
14. Is your child shy around strangers? ***Yes – No***
15. Does your child have a favorite pet or toy? _____

Other Comments:

_____

_____

_____

_____ _____ _____

Patient/Guardian Signature | Print Patient Name | Date

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Lifetime Dental Care. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Surname ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

□ Phone Message
□ Text Message
□ Email
☐ **Any of the Above**
☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

Lifetime Dental Care
Anthony Butchert D.D.S,

822 South Hastings Way ◆ Eau Claire, WI 54701 ◆ (715) 552-1000

PATIENT FINANCIAL POLICY

1 For those with insurance benefits, we are happy to bill your insurance as a courtesy to you. Please note that your insurance contract exists solely between you and your insurance carrier. **We will file your insurance claim, but we cannot guarantee any benefits**. Your insurance plan is a benefit to you to help offset the cost of necessary dental care. **Ultimately, you are responsible for the entire cost of your dental treatment.** In some cases, if you do have insurance coverage, we may still ask you to pay in full on the date of service. Any questions or comments regarding your benefits should be directed to your insurance carrier. If the balance is not cleared within 60 days, you will be charged a billing fee of $5.00 monthly.

2 **Payment at the time of service is expected, or the estimated portion of the amount that insurance does not cover**. Our office accepts the following credit cards: MasterCard, VISA, American Express, Discover and Care Credit. There is a prepay 10% reduction in fees for your next appointment when you make the appointment if paid in full with cash or check at the time of *scheduling* treatment. Sedation appointments, "Invisalign", and credit card payments are excluded from the 10% offer. *Also excluded are patients with PPO contracts due to the contractual discounts in their policies. (Sedation appointments require pre-payment, Invisalign requires $610.00 non-refundable deposit before sending out case. Some of the Invisalign fee may or may not be reimbursed by your insurance depending upon your policy parameters.)*

3 When the patient's portion cannot be paid at the time of service and payment arrangements extend beyond 60 days, a billing fee of $5.00 per month will be charged on all outstanding balances regardless of estimated insurance.

4 A credit qualification will be researched on each new patient before being offered payment arrangements.

5 A statement for services rendered will be mailed to you every four weeks. Receipt of payment is expected within 21 days of the postmark. The patient's payment should be mailed with the top portion of the statement to establish the proper crediting of the account.

6 Your account due is considered delinquent if the requested payment is not received 21 days after billing. If payment is not received, a billing fee of $5.00 per month will be assessed after 60 days, and will appear on the next statement. All fees are subject to change without a new form's being signed.

7 A $35.00 charge will be billed to your account for any check returned by the bank for any reason. We will resubmit the check for payment to the bank one time. However, if funds are still insufficient, we will not accept payments by check from you in the future.

8 There will be no charge for a broken appointment with 24 hours' notice. This enables us to fill the reserved time slot from our list of patients who are able to come on short notice. **Broken appointments with less than 24 hours' notice will incur a fee of $45.**

9 Before records can be transferred, you must sign a privacy release form and pay the $28.00 x-ray duplicating fee if needed.

10 Delinquent accounts after 90 days may be sent to a collection agency or small claims court. **Any fees incurred for the collection of a debt are the responsibility of the patient or guarantor and will be added to the account.**

I have read and understand the financial policy of Dr. Tony Butchert and agree to all the terms described in it.

_____ Date_____
Patient Signature/Guardian Signature

_____
If signed by Guardian, please print patient's name above.