Dr. Paul Broring

Patient Health History

Baldwin **Bloomfield**

Today's Date _____

Child's Name _____ Nickname _____ Weight _____
Date of Birth _____ Referred By _____ Child's Physician _____
Father's Name _____ Mother's Name _____
Home Address _____
Home Phone _____ Cell Phone _____
E-Mail Address _____
Person Responsible for Account _____ Their Date of Birth _____
Dental Insurance Co. _____ or Self Pay _____
Employer _____ Social Security Number _____
Name of Person Completing Form _____ Relationship to Child _____
In Case of Emergency Notify _____ Their Phone Number _____
Father's Place of Employment _____ Occupation _____ Phone _____
Mother's Place of Employment _____ Occupation _____ Phone _____
1. Is your child having any dental problems? _____ Please explain _____
2. Is this your child's first visit to any dentist? _____ If not, date of last visit _____
3. Names and ages of brothers and sisters _____
4. Place of birth _____ Was water fluoridated? _____ Is current water? _____
5. Is your child in good health now? _____ Taking medication? _____
6. Any problems or medications during pregnancy? _____
7. Has your child had any of the following?

Heart disease or defects _____	Anemia or Blood Disorders _____	Frequent Headaches _____
Diabetes _____	Hepatitis or Liver Disease _____	Cleft Palate or Lip _____
Convulsions _____	Bleeding Difficulties _____	Cerebral Palsy _____
Kidney Disease _____	Birth Defects _____	Sight Problems _____
Dizziness or Fainting _____	Hearing Problems _____	Any Other Illness _____
Rheumatic Fever _____	Nervous Condition _____	Delay in Physical
Breathing Difficulties _____	Emotional Problems _____	or Mental Development _____
Blood Transfusions _____	Other Conditions _____	

8. Is your child allergic to any food or drugs? (Penicillin, Novocaine, other local anesthetics, aspirin, etc.) _____
9. Has your child ever been warned by a physician against taking any specific drug medication? _____
10. Has your child ever been hospitalized? _____ When? _____
For what reason? _____
11. Age at which first tooth erupted _____ Did your child sleep with a bottle? _____ What did the bottle contain? _____ At what age did he/she stop _____
12. Does your child brush his/her own teeth? _____ If not who does? _____
When? _____ Type of brush _____
13. Does your child have any speech difficulties? _____
14. What habits does your child have which might affect the teeth or mouth?
Mouth breather _____ Grinding _____ Clenching _____ Sucks Thumb/Finger _____ Other _____
15. Has your child had any dental injuries? _____ Please explain _____
16. Has your child had any fluoride treatments? _____ Date of last treatment _____
17. Has your child ever had fluoride medication at home? _____ Type _____
18. Diet Summary (frequency and types of sweets) _____
19. Dental History of other family members _____
20. Any other information you feel we should know about your child? _____
_____

Dr. Paul Broring Pediatric Dentistry

TREATMENT CONSENT, ACCOUNT RESPONSIBILITY AND FINANCIAL POLICY

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit. We accept Visa, Mastercard, cash, checks, and debit cards. If you have dental insurance, we will be happy to file your claim. Deductibles and estimated copays are due on the day of service. The policy holder is responsible for any balance not paid by the insurance company. We encourage you to check with your insurance company regarding specific coverage and limitations. Please note that Dentistry for Kids uses only composite resin fillings. Some insurance companies limit coverage on these fillings. For larger treatment plans, outside financing is available with low or no interest. Accounts 90 days overdue are subject to collection and additional fees, agency fees, and other charges may apply. There may be a charge for appointments broken or cancelled with less than 48 hours notice.

Father_____ Mother_____

Home Address _____

Home Phone_____ Cell Phone_____

Father Social Security Number _____ Mother Social Security Number_____

If you have dental insurance, please complete the following:

Primary Insurance Plan_____ Phone Number_____

Subscriber _____ ID or Social Security # _____

Group Number _____Date of Birth _____

Employer Name _____

Secondary Insurance Plan_____ Phone Number_____

Subscriber _____ ID or Social Security # _____

Group Number _____Date of Birth _____

Employer Name _____

Being the parent or guardian I do voluntarily consent to the performance of examinations, diagnostic procedures (including x-rays), fluoride treatments, sealants, extractions, and resin fillings or stainless steel crowns for my child. I understand this consent will remain in effect for as long as the patient remains an active patient with Dentistry For Kids, Inc. I understand that I may obtain a Notice of Privacy Practices upon request.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize assignment of my insurance benefits directly to the provider, and authorize the provider to release any information required to process insurance claims. I understand the above information and certify this form was completed to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature_____ Date _____

DR. PAUL BRORING

Baldwin
5208 Clairton Blvd
Pittsburgh, Pa 15236
412-882-1700

Bloomfield
4815 Liberty Ave #106
Pittsburgh, Pa 15224
412-682-7900

Notice of Privacy Practices
Patient Acknowledgement

I understand that, under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations.

I have read and understand that I may submit a written request how my PHI is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by them.

Patient name: _____

Relationship to patient: _____

Signature: _____

Date: _____

Official Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date Initials Reason:

Premier Family Dentistry

Paul J. Broring D.D.S. **5208 Clairton Blvd** **George Felder D.M.D.**

Pediatric Dentist **Pittsburgh, Pa. 15236** **General Dentist**

Patient Name_____ E-mail address_____

Main phone # (H or C)_____Would you like a text reminder. Yes No

Address Change: Yes / No

Have there been any changes in your insurance since your last visit?_____
If yes, please specify: Ins. Carrier_____ ID#_____

Has there been any change in your medical history since your last visit? If so, please explain:_____

Please list prescriptions/medications you are currently taking._____
_____

Do you have any known allergies?_____Latex allergy?_____

Do you consume gummy vitamins?_____

Would you like a fluoride treatment today? Fluoride nourishes the tooth matrix, helps reduce sensitivity, and aids in cavity protection. There is a $40.00 charge if fluoride is not covered by your insurance. Yes_____ No_____

Are you required to take antibiotic premedication before dental appointments?_____

Any additional dental concerns?_____

Treatment consent:

I authorize the staff to perform any necessary services during diagnosis and treatment, including but not limited to exam, prophylaxis, x-rays, sealants, and composite resins. I understand the above information and certify this form was completed to the best of my knowledge.

Patient/Guardian Signature_____ Date_____