CHI St. Joseph Children's Health

# DENTAL CENTER NEW PATIENT FORM

Please print clearly and use pen when completing this form.

## Child Information:

| | | | | |
|---|---|---|---|---|
| **Child's Name** Last | First | Middle Initial | **Preferred Name/Nickname** | |
| **Whom may we thank for referring you?** | | | **Date of Birth** (MM/DD/YYYY) | **Age** |
| | | | **Social Security Number** | |
| **Child's Race**<br>☐ American/Alaskan Native<br>☐ Asian<br>☐ Black, incl. African-American | ☐ Hawaiian/Pacific Islander<br>☐ More than one<br>☐ White<br>☐ Other _____ | | **Child's Ethnicity**<br>☐ Hispanic/Latino<br>☐ Not Hispanic/Latino | |
| **Child's School** | | | **Child's Sex** (check one) ☐ Male ☐ Female | |

## Parent/Contact Information:

| | | | |
|---|---|---|---|
| **Home Phone** ☐ leave messages<br>( ) | **Cell Phone** ☐ leave messages<br>( ) | **Work Phone** ☐ leave messages<br>( ) | **Best Number to Use**<br>☐ Home ☐ Cell ☐ Work |
| **Address** Street | City | State | ZIP Code |
| **Child lives with** (please check one)<br>☐ Both Parents ☐ Mother ☐ Father ☐ Other (please specify): | | | |
| **E-Mail Address** ☐ Okay to contact via e-mail | | | **Text Message Reminders**<br>☐ Yes ☐ No |
| **Parent's or Guardian's Name** | | Phone Number | Relationship to Child |
| **Parent's or Guardian's Name** | | Phone Number | Relationship to Child |
| **Emergency Contact Name** | | Phone Number | Relationship to Child |
| May CHI St. Joseph Children's Health send mail to you at your address?* ☐ Yes ☐ No<br>*This question refers only to mail other than billing and service statements. | | | |

## Household and Insurance Information:

This information assists CHI St. Joseph Children's Health in determining eligibility and additional programs for which you may qualify.

| | | | |
|---|---|---|---|
| Annual Household Income<br>☐ <$9,999<br>☐ $10,000 – $14,999<br>☐ $15,000 – $19,999<br>☐ $20,000 – $29,999<br>☐ $30,000 – $49,999<br>☐ $50,000 – $79,999<br>☐ Over $80,000 | Number of individuals in the household<br>☐ 2<br>☐ 3<br>☐ 4<br>☐ 5<br>☐ 6<br>☐ Other_____ | Child's Primary Spoken Language(s)<br>☐ English<br>☐ Español<br>☐ Français<br>☐ Português<br>☐ American Sign Language<br>☐ Other_____ | Household Veteran Status<br>☐ Veteran<br>(Relation: _____)<br>☐ Not a Veteran |
| Insurance Status<br>☐ Medicaid<br>☐ CHIP<br>☐ Private<br>☐ No Dental Coverage*<br>*Please complete a Request for Services Application. | If enrolled in Medicaid:<br>Medicaid ID#_____<br>☐ *Aetna Better Health*<br>☐ *Amerihealth Caritas*<br>☐ *Gateway*<br>☐ *United Healthcare - Families*<br>☐ *UPMC for You* | If enrolled in CHIP:<br>CHIP ID#_____<br>☐ *Aetna Better Health Kids*<br>☐ *Capital Blue Cross*<br>☐ *Geisinger Kids*<br>☐ *Highmark Blue Shield*<br>☐ *United Healthcare - Kids*<br>☐ *UPMC for Kids* | If enrolled in Private:<br>Member ID#_____<br>☐ *MetLife*<br>☐ *DeltaDental*<br>☐ *Other*_____ |

Application continues ⟶

## Child Medical History:

Name of Doctor/Practice: _____ Phone #: _____
Child's Height: _____ Child's Weight: _____

**My child has/had any history of: (please check all that apply) Indicate none by circling: None**

| | | | |
|---|---|---|---|
| ☐ Bleeding Disorder | ☐ ADHD/ Hyperactivity | ☐ Liver Problems | ☐ Recent Hospitalization/ Surgery |
| ☐ Cancer | ☐ Asthma/ Respiratory Problems | ☐ Thyroid Problems | ☐ Mental Health Concerns: Specify |
| ☐ Cardiovascular / Heart Murmur | ☐ Autism | ☐ Sexually Transmitted Infections | |
| ☐ Hepatitis A, B or C | ☐ Cerebral Palsy | ☐ Other: | _____ |
| ☐ HIV/AIDS | ☐ Diabetes | | |
| ☐ Pregnant | ☐ Epilepsy / Convulsions / Seizures | _____ | |
| ☐ Sickle Cell | ☐ GI / Stomach Problems | | |
| ☐ Steroid Use (Oral ie. Prednisone) | ☐ Kidney Problems | | |

**Current Medications: Indicate none by circling: None**
Please list any medications (including non-prescription drugs, vitamins and herbal supplements) that the child is taking.

| | Medication Name | Dose | Frequency of Use |
|---|---|---|---|
| 1. | _____ | _____ | _____ |
| 2. | _____ | _____ | _____ |
| 3. | _____ | _____ | _____ |
| 4. | _____ | _____ | _____ |

**Allergies: Indicate none by circling: None**
Please list any allergies the child may have, including allergies to medications and foods.

_____ _____ _____

_____ _____ _____

**Dental / Oral Health History:**
Date of your child's last dental visit: ____/____/_____ Reason for visit: _____

Has your child been seen by St. Joseph Children's Health Before? ☐ Yes ☐ No ☐ Unknown
If yes, location: _____

Does your child have any problems with his/her mouth? ☐ Yes ☐ No ☐ Unknown
If yes, please explain: _____

Is your child currently taking Fluoride supplements? ☐ Yes ☐ No ☐ Unknown If yes, dosage: _____

Has your child had any problems with prior dental treatment? ☐ Yes ☐ No ☐ Unknown
If yes, please explain: _____

**HIPPA Privacy Notice, Treatment Consent, Financial Policy, and Cancellation Acknowledgement**

I agree that, to the best of my knowledge, all information on this form is accurate and true. I acknowledge that I have received the HIPAA Privacy Notice. I attest that I have received and read the Consent for Dental Treatment, the Appointment Cancellation Policy, and the Financial Policy or have had it explained to me.

I am the parent/guardian of the child named on this application, and I am authorized to knowingly consent for treatment on behalf of the named child.

_____ _____
Parent/Guardian Signature Date