Peninsula Pediatric Dentistry

Robert E. McAlpine, D.M.D., P.C.
36275 Kenai Spur Hwy., Ste. 1
Soldotna, AK 99669

P: 907-260-5439 (KIDZ) • F: 907-260-5447

Thank you for selecting Peninsula Pediatric Dentistry! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Please share with us how you were referred:

YOUR CHILD

Child's Name: Last First Middle Initial	First Dental Visit ☐ Yes ☐ No
Nickname:	Sex: ☐ Male ☐ Female
Birthdate: SSN#:	Age:
Child's Street Address:	
City: State: Zip:	

RESPONSIBLE PARTY

Name: Last First Middle Initial	Name: Last First Middle Initial
☐ Mother ☐ Other	☐ Father ☐ Other
Mailing Address:	Mailing Address:
City: State: Zip:	City: State: Zip:
SSN#: DL#:	SSN#: DL#:
Home#: Cell:	Home#: Cell:
Email:	Email:
Employer: Work #	Employer: Work #
Spouse (if not Father):	Spouse (if not Mother):

PRIMARY INSURANCE	SECONDARY INSURANCE
Insured's Name:	Insured's Name:
Relationship to Child:	Relationship to Child:
Birthdate: SS#:	Birthdate: SS#:
Employer: Work #	Employer: Work #
Occupation:	Occupation:
Insurance Co:	Insurance Co:
Group #: Subscriber #	Group #: Subscriber #
Ins Co Address:	Ins Co Address:
City: State: Zip:	City: State: Zip:

Emergency Contact: Name: _____ Phone Number _____ Relationship _____

People authorized to bring your child in for treatment:

Name: _____ Relationship _____

Name: _____ Relationship _____

Parent's Signature _____ Date _____

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DENTAL HISTORY (CONFIDENTIAL)		
Medications and your child's overall health have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.		
Date of last dental visit:		
Has your child had difficulty with previous dental visits?	☐ Yes Please explain:	☐ No
Are you aware of any problems with your child's mouth or teeth?	☐ Yes Please explain:	☐ No
Has your child injured head, mouth, or teeth?	☐ Yes	☐ No
Does your child take fluoride supplements?	☐ Yes	☐ No
Does your child have a history of, or is your child currently doing any of the following?		
Pacifier	☐ Yes	☐ No
Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Was your child?		
Bottle Fed	☐ Yes When weaned:	☐ No
Breast Fed	☐ Yes When weaned:	☐ No

MEDICAL HISTORY (CONFIDENTIAL)		
Physician's Name:	Phone #:	
Date of Last Visit:		
Previous Hospitalizations/Surgeries/ Serious Illnesses:	☐ Yes Please explain (include dates):	☐ No
Are immunizations up to date?	☐ Yes	☐ No
Is your child taking any medications?	☐ Yes Which ones:	☐ No
Is your child allergic to any medications?	☐ Yes Which ones:	☐ No
Does your child have any other allergies?	☐ Yes Please explain:	☐ No

Patient's Name _____ Date of Birth _____

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HEALTH HISTORY (CONFIDENTIAL)

Do any of the following apply to your child?

Anemia	☐ Yes	☐ No	Abnormal bleeding	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Handicap/Disabilities	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No	Skin disorders	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Heart Conditions/Murmur	☐ Yes	☐ No
Premedication needed	☐ Yes	☐ No	Nose/Throat disorders	☐ Yes	☐ No
Lung disorders	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No	Cancer/Tumors	☐ Yes	☐ No
Stomach/kidney problems	☐ Yes	☐ No	Liver problems	☐ Yes	☐ No
Convulsions/epilepsy	☐ Yes	☐ No	Ear problems	☐ Yes	☐ No
Bone problems	☐ Yes	☐ No	Speech/Vision problems	☐ Yes	☐ No
Hyperactivity/ADD/ADHD	☐ Yes	☐ No	Mental/Emotional disorders	☐ Yes	☐ No
Latex allergy	☐ Yes	☐ No	Premature at birth	☐ Yes	☐ No
Complications during pregnancy	☐ Yes	☐ No	Blood transfusions	☐ Yes	☐ No
Sickle Cell Disease	☐ Yes	☐ No	Eating disorders	☐ Yes	☐ No
Thyroid/Gland disorders	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Pregnancy	☐ Yes	☐ No	Genito-urinary problems	☐ Yes	☐ No

Please explain any medical conditions/issues about which you would like us to know: _____

_____

Does your child have Special Needs? ☐ Yes ☐ No I you chose yes, please check all boxes that apply.

☐ ADHD	☐ Wheel chair
☐ Behavior disorder	☐ Hearing impairment
☐ Autism	☐ Head injury
☐ Depression	☐ Developmental challenges
☐ Down Syndrome	☐ Nervous disorders
☐ Cerebral Palsy	☐ Psychological disorders
☐ Vision impairment	☐ Bipolar depression
☐ Spina Bifida	

If you checked any of the above, please explain: _____

_____

Does your child have anything that has not been previously mentioned? ☐ Yes ☐ No

If you answered yes, please explain: _____

_____

Patient's Name _____ Date of Birth _____

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CONSENT FOR MEDICAL TREATMENT / AUTHORIZATION FOR BILLING

AUTHORIZATION FOR CARE & TREATMENT: I hereby agree that Robert E. McAlpine, D.M.D., P.C. may perform care and treatment , and may conduct such examinations, laboratory tests and procedures (including x-rays), administer such local anesthetics, analgesia medication and treatment , as may be directed by my treating practitioner. I acknowledge that no guarantees have been made to me as to the effect of such examinations, tests, procedures or treatment of my condition.

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I have made in the completions of this form.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I consent to the use and disclosure of my Protected Health Information by Robert E. McAlpine, D.M.D., P.C. for purposes of treatment, payment, and health care operations. For example, my treating practitioner, Robert E. McAlpine, D.M.D., P.C., may furnish Protected Health Information maintained by Peninsula Pediatric Dentistry, in the course of my care and treatment. Release of medical records and information will be made according to state and federal regulations. I understand that Robert E. McAlpine, D.M.D., P.C., may release medical information to any third party.

INSURANCE AUTHORIZATION: I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain services in order for my insurance company to pay for those services and I understand that I am personally responsible for payment if I do not obtain any necessary prior authorization or my insurance benefits are denied, reduced, or terminated.

ASSIGNMENT OF BENEFITS, INSURANCE PROCEEDS, and SETTLEMENTS: If I am entitled to health care services under any insurance policy from any person or organization which may become liable to me to provide such benefits, I assign such benefits to Robert E. McAlpine, D.M.D., P.C. and practitioners employed by the practice who render such services to me. I further authorize payment directly to Robert E. McAlpine, D.M.D., P.C. and such practitioners of all such insurance benefits payable to me. Such insurance may include, but is not limited to, private commercial insurance, auto liability insurance programs such as Medicaid or other government sources.

I certify that the information given regarding my insurance is accurate and current to the best of my knowledge.

I further assign to Robert E. McAlpine, D.M.D., P.C. any payments for medical benefits payable to me as a result of any settlement or judgment in a lawsuit.

FINANCIAL AGREEMENT: In consideration for services rendered by Robert E. McAlpine, D.M.D., P.C. and practitioners employed by Peninsula Pediatric Dentistry, I guarantee prompt payment of all such services not paid by insurance carriers or third parties within thirty (30) days. I understand that any amount not covered by my insurance carrier or other third party payers is my personal responsibility, and I agree to pay any such amount. If Robert E. McAlpine, D.M.D., P.C. does not receive such payment within thirty (30) days from the date such balance is due, the bill may be turned over to an attorney or a collection agency and, if so, I agree to pay all reasonable collection costs including attorney's fees and/or collection fees in addition to the payment owed. I give Robert E. McAlpine, D.M.D., P.C. the right to examine my consumer credit report for financial information related to my responsibility to pay for Dental services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I acknowledge that I have received the Peninsula Pediatric Dentistry Health Notice of Privacy Practices. A copy is available upon request.

DISCLOSURE TO FAMILY OR FRIENDS INVOLVED IN MY CARE: I understand that I may limit the disclosure of my health information to family members, or other close relatives or close personal friends by notifying a member of the staff assigned to care for me.

I have read all the above statements and accept the terms and conditions as stated.

Patient/Parent /Agent/Guardian signature:	Date	Time
Witness Signature	Date	Time