Steven Shandley, D.D.S.
M. Elizabeth Kane, D.D.S.

33 W Higgins Rd, Suite 800
S Barrington, IL 60010
(847) 428-4646
www.skdentistry.com

Family Dental Care

Children's New Patient Intake Form

Date_____

Child's Name_____ Age_____ Date of Birth_____

Parents' Names_____

Address_____City_____ Zip_____

Parent's Marital Status (M)_____(S) _____(D)_____With whom do the children reside? _____

Telephone: Residence_____ Father Work/Cell _____

Email Address_____ Mother's Work/Cell _____

With whom may we discuss child's treatment? (Check all that apply) **AND SIGN BELOW**

_____Parent(s) _____Custodial parent only _____Childcare person

_____Other family member/friend _____
Name/relationship

_____
Signature

Father Employed By_____How Long _____

Mother Employed By_____How Long _____

Referred By (or how did you hear about our office) _____

Dental Insurance: **If you have dental insurance please complete the Dental Insurance Info form that follows.**

Parent's Social Security Numbers: Father _____

Mother _____

Parent's Driver's License Numbers: Father _____

Mother _____

Emergency contact (other than parent) _____ Relationship to Child _____

Phone Number(s) _____

-Over-

Please answer all questions. If there are any questions that you do not understand, please ask, we will be happy to assist you. All information is held in the strictest of confidence. Thank you for providing us with this information.

Dental History

Why are you bringing your child to the dentist?_____

Has your child ever been to the dentist? ____Yes _____No If yes, date of last dental visit_____

If yes, how was your child's past dental experience? Positive Negative

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

____Yes_____No If yes, please explain_____

How often does your child brush?_____Floss?_____Do you assist?_____

Briefly describe any past dental trauma_____

Circle Y or N if your child has had any of the following:

Y/N	Bad breath	Y/N	Sensitivity to cold/hot	Y/N	Loose teeth or broken fillings
Y/N	Bleeding gums	Y/N	Sensitivity when biting	Y/N	Food collection between teeth
Y/N	Grinding or clenching teeth	Y/N	Sensitivity to sweets	Y/N	Sores or growth in mouth
Y/N	Clicking or popping jaw	Y/N	Finger, thumb or pacifier habit	Y/N	Fluoride supplements

Medical History

Name of child's physician_____ Phone #_____

Date of last visit_____Is your child's immunization up to date?_____Yes_____No

Is your child presently under medical care? Y/N If yes, explain_____

Is your child currently taking medications? Y/N If yes, reason_____

Medications presently being taken_____

Has your child ever been hospitalized or put to sleep for an operation? Y/N If yes, please list dates & procedures:

_____

Has child's physician ever recommended antibiotics for dental treatment? Y/N If yes, reason_____

Does your child see a specialist? Y/N If yes,reason_____

Does your child have or has child ever had allergies or reactions? Y/N If yes (please circle all that apply): **Penicillin Erythromycin Sulfa Anesthetics Latex Foods** (list)_____

Other_____

Circle Y or N if your child has had any of the following medical problems

Y/N	Heart disease	Y/N	Abnormal bleeding from a cut	Y/N	Asthma/breathing problems
Y/N	Heart murmur	Y/N	Frequent nose bleeds Unexplained	Y/N	Seizures/Epilepsy
Y/N	Congenital heart defect	Y/N	bruising	Y/N	Diabetes
Y/N	Rheumatic Fever	Y/N	Hemophilia/bleeding disorder	Y/N	Hepatitis
y/N	Mononucleosis (Mono)	y/N	Anemia	Y/N	HIV+/AIDS
Y/N	Bone problems	y/N	Blood transfusions	Y/N	Cancer

Other Medical Conditions_____

Characterize your child's mental development._____Normal_____1-2 years behind_____More than 2 years behind Has your child been diagnosed with: Autism Y/N Aspergers Syndrome Y/N ADHD Y/N

Other developmental conditions Y/N If yes,please explain_____

I understand the information given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical condition.

Signature of parent or guardian_____Date_____

Insurance Information:

Primary Insurance Carrier: _____

ID#: _____ Group #: _____

Address to submit the claim:

_____

Street City State Zip Code _____

Policy Holder's Name: _____

SS#: _____

Date of Birth: _____/_____/_____ Relationship to Child: _____

Employer Name: _____

Secondary Insurance Carrier: _____

ID#: _____ Group #: _____

Address to submit the claim:

_____

Street City State Zip Code _____

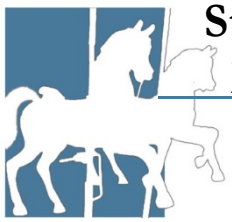
Policy Holder's Name: _____

SS#: _____

Date of Birth: _____/_____/_____ Relationship to Child: _____

Employer Name: _____

I DO NOT YOU HAVE ANY OTHER INSURANCE COVERAGE FROM ANY OTHER SOURCE OTHER THAT THE ABOVE MENTIONED. Initial _____



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Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received/ been offered a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____ Date: _____

I give permission to leave health information and/ or appointment information on my answering system at: (Please check all that apply)

Home_____ Work_____ Cell_____ _____ (Initial)

I give permission to discuss health care information with:

Name_____Relationship_____

Contact number_____

_____ (Initial)

May we have your permission to show our appreciation and send a thank you to the person who referred you to our practice? (Please circle one) Yes or No

_____ (Initial)

Right to Revoke:

I have the right at any time to revoke this Acknowledgement for any reason.

Signature: _____Date:_____

E-mail Statement and Acknowledgment:

It is our office's goal to keep your information confidential and secure. Being that most E-mail systems are unencrypted, there are inherent risks with E-mail (e.g. interception, alteration). If you understand the risks associated with E-mail and would still like to be communicated with in that way, please acknowledge below.

_____ (Initial)

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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HIPAA Consent To Leave A Message

Patient Name: _____ Date: _____
(print)

I wish to be called at: (fill all that apply)

Home: _____

Cell: _____

Other: _____

Regarding my care and follow-up.

- ❑ I do
- ❑ I do not

Give permission to leave relevant medical information on my answering machine or voice mail. These might include: treatment plans, pre-medication reminders, and general Protected Health Information.

- ❑ I do
- ❑ I do not

Want relevant medical information to be shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you man leave Protected Health Information are:

1. _____
2. _____
3. _____

_____ _____
Patient Signature Date

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How Often Do You Take the Medication	Reason for taking medication	Prescriber

Known Allergies:

List any reaction you have experienced from medicines that have had bad side effects. Also include any allergy to dye, food, etc.

Signature: **Date:**