



5320 S. Macadam Ave. #100  
Portland OR 97239

### PEDIATRIC NEW PATIENT FORMS

#### TELL US ABOUT YOUR CHILD

Child's Name \_\_\_\_\_  
                                    First                                    Middle Initial                                    Last  
Nickname \_\_\_\_\_ Gender \_\_\_\_\_  
Child's Birthdate \_\_\_\_\_ Child's Age \_\_\_\_\_  
Child's Home Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
How did you choose our office? \_\_\_\_\_

#### OTHER INDIVIDUALS AUTHORIZED TO CONSENT FOR TREATMENT

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Signature \_\_\_\_\_  
If treatment involves nitrous oxide, individual must be 18 years or older to bring child.

#### PARENT 1 INFORMATION

Mother     Father     Guardian     Foster Parent  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Primary # \_\_\_\_\_ Secondary # \_\_\_\_\_  
Birthdate \_\_\_\_\_ SSN \_\_\_\_\_  
Email Address \_\_\_\_\_  
Marital Status  Single  Married  Separated  Widowed  Divorced  
Do you have legal custody of this child?     Yes     No

#### EMERGENCY CONTACT OTHER THAN LEGAL GUARDIAN

Name \_\_\_\_\_  
Relationship \_\_\_\_\_ Phone \_\_\_\_\_

#### PARENT 2 INFORMATION

Father     Mother     Guardian     Foster Parent  
Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Primary # \_\_\_\_\_ Secondary # \_\_\_\_\_  
Birthdate \_\_\_\_\_ SSN \_\_\_\_\_  
Email Address \_\_\_\_\_  
Marital Status  Single  Married  Separated  Widowed  Divorced  
Do you have legal custody of this child?     Yes     No

**PRIMARY DENTAL INSURANCE**

Insurance Co. Name \_\_\_\_\_  
Insurance Co. Phone \_\_\_\_\_  
Subscriber Member # \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy Owner's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Policy Owner's Birthdate \_\_\_\_\_  
Policy Owner's Employer \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Insurance Co. Name \_\_\_\_\_  
Insurance Co. Phone \_\_\_\_\_  
Subscriber Member # \_\_\_\_\_  
Group # \_\_\_\_\_  
Policy Owner's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Policy Owner's Birthdate \_\_\_\_\_  
Policy Owner's Employer \_\_\_\_\_

**Main reason for today's visit:** \_\_\_\_\_

**DENTAL HISTORY**

- How often are the child's teeth brushed?  1x/day  2x/day  Every Other Day  Not Regularly
- How often are the child's teeth being flossed?  1x/day  2x/day  Every Other Day  Not Regularly
- Who does the brushing and flossing?  Parent  Child  Half/Half  None
- Fluoride Use?  Rx by MD/DMD  in H2O  Toothpaste  Rinse  None
- Does your child have any oral habits?  Thumb/Finger  Binky  Mouth Breather  Grinding  None
- History of Dental Trauma? If yes, please explain: \_\_\_\_\_
- How would you rate mother's oral health?  Excellent  Good  Fair  Poor  I don't know
- How would you rate father's oral health?  Excellent  Good  Fair  Poor  I don't know
- How would you rate your child's sugar consumption? (candy, juice, etc.)  Low  Average  High
- When was your child weaned off nursing/bottle?  6 Months  12 Months  24 Months  Still Use  I don't know

**MEDICAL HISTORY**

- Is your child under a physician's care other than his/her PCP?  Yes  No If yes, explain \_\_\_\_\_
- Has your child ever been hospitalized or had any surgeries?  Yes  No If yes, explain (list dates) \_\_\_\_\_
- Has your child ever had any serious complications from general anesthesia?  Yes  No If Yes explain \_\_\_\_\_
- Has your child ever had a serious head injury?  Yes  No If yes, explain \_\_\_\_\_

**DOES YOUR CHILD HAVE ANY ALLERGIES?**

<input type="checkbox"/> None	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Penicillin/Amoxicillin	<input type="checkbox"/> Codeine
<input type="checkbox"/> Acrylic	<input type="checkbox"/> Augmentin	<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Metal
<input type="checkbox"/> Latex	<input type="checkbox"/> Sulfa drugs	<input type="checkbox"/> Local anesthesia	<input type="checkbox"/> Zithromax
<input type="checkbox"/> Other _____			

**IS YOUR CHILD TAKING ANY MEDICATIONS?**

Please list all medications your child is currently taking:  None

\_\_\_\_\_

\_\_\_\_\_

**DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?**

Yes	No	Yes	No	Yes	No	Yes	No
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5320 S. Macadam Ave. #100  
Portland OR 97239

## Welcome Agreement

Welcome to our family of patients. We are delighted you have chosen the Geelan Dental team to provide you with your oral health care. We are committed to providing you with the highest quality dentistry, and look forward to building a partnership to keep you and your smile as healthy as possible.

We look forward to getting to know you better through the years to come, and happily welcome you to our practice. As a courtesy to you, we gladly process your insurance claims and provide you with an estimate of your co-pay for each visit. Each estimate is based off information given to us by your insurance carrier and is only an estimate. Ultimately you are responsible for any charges not paid by your plan. Please read your insurance benefit booklet and understand all waiting periods, frequency limitations, exceptions, and exclusions. Please know that we do everything possible to see that you receive the full benefits from your insurance company. If for some reason your insurance company has not paid their portion within 60 days from the start of your treatment, you are responsible for payment at that time.

We kindly ask that if you are unable to keep a scheduled appointment that you give two business days notice so that we can make every effort to accommodate other patients. With respect to the staff that serves you and to the patients who depend on us, we appreciate timely cancellation notifications and alerts if you are running late. **If two business day notice is not received, there will be a customary fee of \$60 charged to your account. For all missed appointments with no notice, there will be a fee of \$100 charged to your account.** Our business days and hours are Monday - Thursday 7:30am - 4:30pm.

I understand the cancellation policy \_\_\_\_\_ (initial here)

**We collect all out of pocket expense in full on the date of service.** If you have a financial concern, we are happy to share with you our Care Credit payment plan options. There are no interest options available as well and low interest extended plans designed to fit every budget.

I acknowledge that I understand the information listed above and consent to the welcome agreement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to the Patient: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT



5320 S. Macadam Ave. #100  
Portland OR 97239

## Acknowledgement of Privacy Practices

Name: \_\_\_\_\_

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information we maintain.

You may obtain a copy of our Notice of Privacy Practices  
at any time by contacting any staff member of Geelan Dental Care  
using email address: [info@geelandental.com](mailto:info@geelandental.com)

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact email listed above. Please understand that revocation of this Consent will not affect any action taken in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient,

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT