DR. BRAD WELSH
GENERAL • BRACES • IMPLANT
DENTISTRY

welcome

Patient's Name ______________________________
Last First Initial Nickname Date of Birth

Parent's Guardian's Name ______________________________

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

COMMENTS

1. Is this your child's first visit to a dentist? .... YES NO
2. If not, how long since the last visit to the dentist? ____________
3. Were any x-rays or radiographs taken when your child previously visited the dentist? ... YES NO
4. Does your child eat between meals? .... YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? .... YES NO
6. When does your child brush his/her teeth?
   ❐ Upon arising ❐ After eating any food ❐ Right after meals ❐ Before going to bed
7. How does your child receive Fluoride?
   ❐ Community water level ____ ppm ❐ Well water level ____ ppm
   ❐ Fluoride drops or tablets ❐ Fluoride rinse or gel
8. Have any cavities been noted in the past? .... YES NO
9. Does your child suck his/her thumb or fingers? .... YES NO
10. Were any teeth (baby or permanent) removed by extraction? .... YES NO
    Was it suggested that the space be maintained .... YES NO
    Was an appliance placed .... YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc? .... YES NO
    If so describe ____________
12. Has your child had any problem with dental treatment in the past? .... YES NO
13. Has anyone in the family, including parents, had orthodontics? .... YES NO
14. Has your child ever received a local anesthetic? .... YES NO
15. Has your child ever had occlusal sealants? .... YES NO
16. Does your child think there is anything wrong with his/her teeth? .... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? .... YES NO
2. Is your child under care of physician? .... YES NO
   If yes, since when and why? ____________
3. Name of physician ____________ Phone ____________
4. Is your child receiving any medication? .... YES NO
   What? ____________
5. Is your child allergic to penicillin, antibiotics or other drugs? .... YES NO
6. Is your child allergic to or sensitive to any metals or latex? .... YES NO
7. Does your child have other allergies? .... YES NO
8. Has your child had any serious illness? .... YES NO
   When ____________ What ____________
9. Has your child ever had surgery? .... YES NO
10. Does your child have a heart murmur? .... YES NO
11. Is surgery contemplated? .... YES NO
12. Does your child experience severe or prolongated bleeding? .... YES NO
13. Does your child have AIDS or has he/she tested HIV positive? .... YES NO
14. Has your child tested positive for hepatitis? .... YES NO
15. Is your child subject to nervous disorders? .... YES NO
    ❐ Fainting? ❐ Seizures? ❐ Dizziness? ❐ Behavioral/Learning problems?
16. Does your child have frequent headaches? .... YES NO
17. Has your child had history of: (Circle appropriate responses) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S / GUARDIAN'S SIGNATURE ____________ DATE ____________

DENTIST'S SIGNATURE ____________ DATE ____________

ANEST.

MED. ALERT

TPI - Form 24803a

CHILD DENTAL MEDICAL HISTORY

Dr. Brad Welsh & Associates, Inc. Office Financial Guidelines

Thank you for choosing Dr. Brad Welsh & Associates. The following are our financial guidelines. Please review, initial where indicated, sign and date at the bottom.

Insurance:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you receive your maximum allowable benefits.

Our doctors will diagnose treatment based on your dental health not your insurance coverage.

We will forward any items that the insurance company may request and help in any way we can to get your claim paid. If insurance is requesting information from you; we will contact you and it is your responsibility to get the insurance company the information they require to process your claim. If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and be reimbursed when your insurance company pays. After 90 days you are responsible to pursue payment from the insurance company.

INITIAL: ________

Account Balance:

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that payment is due at the time of service unless other arrangements have been made. I agree that I am responsible for payment of all services rendered regardless of insurance coverage, if applicable. I understand that a 3% (36%APR) late fee may be added to any account balance over 60 days. If required, I also understand that a credit history inquiry may be made. There will be a $30.00 charge for returned checks. Failure to keep agreed financial arrangements can be cause for the cancellation of any future appointments.

INITIAL: _______

Missed Appointments:

In order to serve you better and reduce the cost of dental care, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24 hours notice for any cancelled appointment. If an appointment is missed or cancelled in less than 24 hours, we reserve the right to charge a broken appointment fee of $50.00. We realize there are sometimes extenuating circumstances that will keep you from keeping a dental appointment. That is taken into consideration prior to charging the broken appointment fee.

INITIAL: ________

Patient Responsibilities:

Discourteous, rude or inappropriate behavior toward our doctors and/or staff can be cause for immediate termination of the relationship with this office.

INITIAL: ________

My signature below indicates that I have read and agree to the above written financial guidelines of Dr. Brad Welsh & Associates.

Signature of Responsible Party/Date:____

Patient Registration
CONFIDENTIAL

Patient Information

Name____(____________________) Date of Birth__________
First MI Last Nickname

Address__________________________________ City____________________ State_______ Zip_________

Home Phone___________________ Work Phone___________________ Cell_________________________

E-Mail Address_____________________________ I prefer to be called at ❑Home ❑Work ❑Cell ❑Any

Are you: ❑Male ❑Female

❑Minor_________________ ❑Single ❑Married__________________ ❑Divorced ❑Separated ❑Widowed
Parents' names Spouse's name

Employer (or School, if minor)______________________________ Occupation_______________________

Social Security Number_______________________ Whom may we thank for referring you?________________

Other Family members in the practice:____

Person to contact in case of an emergency:____
Name Phone Relationship

Responsible Party

Complete this section if responsible party is someone other than the patient.

Name____Date of Birth________ Relationship to patient_______
First Last

Social Security Number_______________________ Employer______________________________________
Name Phone

Address__________________________________ City____________________ State_______ Zip_________

Home Phone___________________ Work Phone___________________ Cell_________________________

Currently a patient in this office? ❑Yes ❑no

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that payment is due at the time of service unless other arrangements have been made. I agree that I am responsible for payment of all services rendered regardless of insurance coverage, if applicable. I understand that a 2.5% (25% APR) late fee may be added to any account balance over 60 days. If required, I also understand that a credit history inquiry may be made.

Responsible Party's Signature____________________________________ Date______________________

Dental Benefit Information

If you have no dental benefits disregard this section.

Primary Plan

Name of Policy Holder_______________________________
Address____
Phone_______________ E-Mail_________________________
Birthdate_______________Relationship to patient__________
Social Security Number______________________________
Employer____
Insurance Co. Name__________________________________
Insurance Co. Address_______________________________
Group Number_________________ ID #__________________

Secondary Plan

Name of Policy Holder_______________________________
Address____
Phone_______________ E-Mail_________________________
Birthdate_______________Relationship to patient__________
Social Security Number______________________________
Employer____
Insurance Co. Name__________________________________
Insurance Co. Address_______________________________
Group Number_________________ ID #__________________

I hereby authorize benefit payment directly to Dr. Brad Welsh's Office. I authorize this office to release any information my insurance company asks for, such as radiographs, dental history, and office/clinical notes. I understand that I am ultimately responsible for all costs of dental treatment.

Primary Policy Holder Signature: ______________________________ Secondary Policy Holder Signature: ______________________________

Financial Responsibility Notice

Customers with an outstanding balance of 90 days or more must make arrangements for payment to our office. It is known to me that should I fail to pay unpaid charges for more than 90 days, my account may be reviewed for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed including court costs and attorney fees.

Signature: ____

AUTHORIZATION FOR USE AND/OR RELEASE OF INFORMATION:

Below, list the names of any individuals/organizations that you authorize the employees of Dr. Brad Welsh & Associates to share/disclose your protected health information (PHI) with. For example: name, radiographs, progress notes, prescriptions, photographs, images, etc.

1. Name: ____________________________________ Relationship: ____________________
2. Name: ____________________________________ Relationship: ____________________

I further authorize this information to be shared and discussed with: the aforementioned; my dental and/or medical insurance company; and myself by, including but not limited to: telephone, facsimile, unencrypted and/or encrypted email, encrypted and/or unencrypted portable storage media (e.g. CD, thumb dive, portable hard-drive, etc.) and/or by conventional mail, and I hereby authorize the aforementioned parties to discuss my PHI with employees of Dr. Brad Welsh & Associates in the same manner. I understand that some of these listed forms of communication are not secure and may be intercepted by unintended parties. If I have any objection to the sending of my PHI through unsecure channels and/or specifically desire that my PHI not be shared through unencrypted email, then I would not sign this Authorization. The Authorization for release of information from Dr. Brad Welsh & Associates covers all past, present and future periods of time or which I choose to revoke said authorization in writing.

I understand that I have the right to revoke this Authorization from an or all of the aforementioned entities independently.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned by any employee of Dr. Brad Welsh & Associates on whether or not I sign this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____________________________________ ______________________________ _________________________

Printed name Signature Date

____________________________________ ____________________________________

Relationship to patient if other than patient Patient's Name

______ I give consent for Dr. Brad Welsh & Associates to leave a message on my answering machine and/or voicemail that could include personal health information for myself or one of my dependents (if applicable)