Dr. Louis LaTulippe
Pediatric Dentist
6 Pearl Drive
Ormond Beach, FL 32174
(386) 671-0404

Welcome to Dr. LaTulippe's Office.

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that will last a lifetime.

About Your Child

Full Name: Last _____ First_____ MI_____

Address: _____ APT/Unit #_____

City_____ State _____ Zip code _____

Primary Phone: _____ Alternate Phone : _____

E-mail Address: _____

Interests, Sports or Hobbies: _____

_____

Date of Birth (MM/DD/YYYY): _____ Male ___ Female ___ Referred by: _____

Sibling's Names and age (if any): _____

About Parents

Mother's Information

Name: Last _____ First_____ MI_____

Address: _____ APT/Unit #_____

City_____ State _____ Zip code _____

Primary Phone: _____ Alternate Phone : _____

E-mail Address _____

Employer: _____ Work Phone #: _____

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Father's Information

Name: Last _____ First_____ MI_____

Address: _____ APT/Unit #_____

City_____ State _____ Zip code _____

Primary Phone: _____ Alternate Phone: _____

E-mail Address _____

Employer: _____ Work Phone #: _____

Dental Insurance Information

Insurance Name: _____ Phone #: _____ Group #: _____

Insured by : ___ Mother ___ Father ___ Other Relationship to Patient : _____

Insured's Name : _____ Employer: _____

Birth Date of Insured : _____ Social Security # Insured: _____

Medical/Dental History

Please check all that applies to the patient:

- ☐ Anemia
- ☐ Asthma, Lung Problems
- ☐ Bleeding Problems
- ☐ Blood Pressure Problems
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Delayed Development
- ☐ Diabetes
- ☐ Ear Infections
- ☐ Emotional Disturbances
- ☐ Fainting Spells
- ☐ Hearing Loss, Impairment
- ☐ Pregnant
- ☐ Herpes
- ☐ Kidney Disease
- ☐ Rheumatic Fever
- ☐ Liver Disease, Hepatitis
- ☐ Malignancy, Cancer
- ☐ Mental Retardation
- ☐ Heart Conditions, Murmur
- ☐ Immunologic Disorder/HIV
- ☐ Seizures, Epilepsy
- ☐ Psychiatric Problems
- ☐ Sickle Cell Anemia

Is your child ALLERGIC or has had an ADVERSE REACTION to any medication?

___ Yes ___ No If Yes: _____

Please list any medications child is currently taking: _____

_____

Any Problems Not Listed above: _____

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Child's Physician Name: _____ Last Exam Date _____

Immunizations up to date ___ Yes ___ NO

Is this your child's **1st** visit to the dentist ___ Yes ___ NO If NO last visit Date? _____

Is your home supplied by ___ well or ___ city Water?

Does your Child receive Fluoride-tablets, drops, vitamins or rinse? ___ Yes ___ NO

Has your Child ever had Orthodontic Treatment? ___ Yes ___ NO

Does your child brush his/her teeth daily ___ Yes ___ No Do you assist? ___ Yes ___ No

Does your child suck his/her thumb or finger or similar habits? ___ Yes ___ No

What age was bottle or breast feeding stopped? _____

Has your child complained **about pain, swelling or other problems**? ___ Yes ___ No

If **YES** please note complaint: _____

Are you and/or your child happy with his/her:

Facial Appearance? ___ Yes ___ No Appearance of teeth? ___ Yes ___ No

Would you predict your child's behavior to be: ___ Cooperative ___ Fearful ___ Defiant ___ Don't Know

What are your concerns about your child's oral health? _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. Your child is a minor; therefore it is necessary that signed permission be obtained from a parent or guardian before necessary dental services can be started. I give consent for Dr. Louis LaTulippe and staff to perform my child's oral examination and necessary treatment. All necessary treatment will be explained prior to commencement. When treatment requires local anesthesia; we can administer nitrous oxide (laughing gas), to relax the patient and make treatment more pleasant.

The parent or guardian who accompanies the child is responsible for payment at the time services are rendered unless prior arrangements have been approved.

___ By checking this box and signing below you are electronically acknowledging the above statement.

Parent/Guardian Date

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Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor child. I accept full financial responsibility for all charges not covered by insurance.

In the event my account balance remains unpaid in excess of 90 days, I understand that my account will be turned over to a collection agency. I accept full responsibility for all administrative costs and legal fees associated with the collection process.

Assignment and Release

I, the undersigned, have insurance with _____ and assign directly to the dentist all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance **within 60 days from the date of service.** I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I understand that there is a broken appointment policy and that I will be charged *$30.00*, unless I notify the office within *1 business day* of my cancellation.

For your convenience our office takes personal checks. However, I understand a *$50.00 fee* will be applied to my account for any bounced check (NSF) and from that point forward, personal checks will no longer be an acceptable form of payment.

___ By checking this box and signing below you are electronically acknowledging the above statement.

Signature Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below name(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing. _____
_____

Signature Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement for 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)

_____

_____

_____