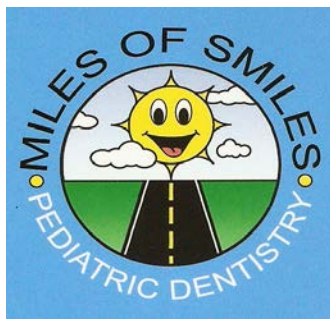


Dr. Louis LaTulippe  
Pediatric Dentist  
6 Pearl Drive  
Ormond Beach, FL 32174  
(386) 671-0404



**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 # \_\_\_\_\_

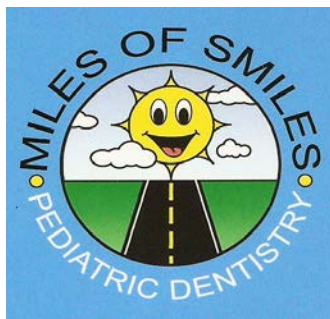
City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

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:

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

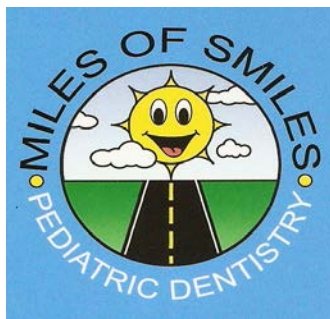
Is your child ALLERGIC or has had an ADVERSE REACTION to any medication?

\_\_\_ 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 1<sup>st</sup> 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.

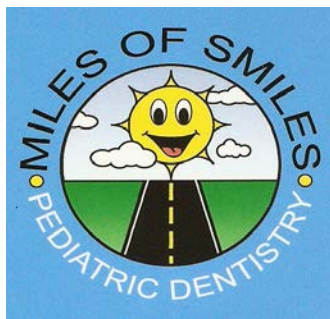
**The parent or guardian who accompanies the child is responsible for payment at the time services are rendered unless prior arrangements have been approved.**

\_\_\_ 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.**

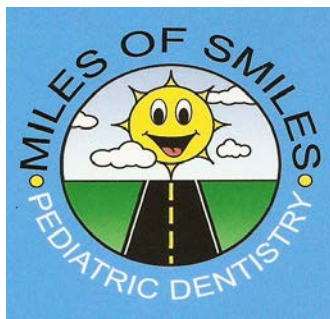
\_\_\_ By checking this box and signing below you are electronically acknowledging the above statement.

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Signature

Date

Dr. Louis LaTulippe  
Pediatric Dentist  
6 Pearl Drive  
Ormond Beach, FL 32174  
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## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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\*You May Refuse to Sign This Acknowledgement\*

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

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

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Signature

Date

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FOR OFFICE USE ONLY

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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)

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