William J. Heimann, D.D.S.
1526 W. Glendale Avenue, Suite 103
Phoenix, Arizona 85021-8576
(602)864-1080 Fax (602)864-7036

PATIENT INFORMATION

Today's Date_____

Child's Name_____ M_____ F_____ Nickname_____

Date of Birth_____ Age _____

Name and Ages of Brothers and Sisters _____

_____

Child's Former Dentist_____ Address _____

Child's Physician_____Address_____

Father's Full Name_____Birth Date:_____ S.S. #_____

Mother's Full Name_____Birth Date:_____ S.S. #_____

Single_____ Married_____ Separated_____ Divorced_____ Widowed_____

Home Address_____ City_____

State_____ Zip Code_____ Home Phone _____

Mailing Address if different _____

Father Employed By _____

(if self-employed, please state business name)

Occupation_____ Business Address_____ Phone _____

Mother Employed By _____

(if self-employed, please state business name)

Occupation_____ Business Address_____ Phone _____

Referred By _____

Nearest Friend or Relative in Phoenix _____

Address_____Phone_____

Name of Dental Insurance, if Any _____

Cell Phone #_____

Although we will be happy to file your insurance for you, we do expect payment of your portion of the charges at the time the services are rendered. We will give an estimate of this amount or will send for a pre-authorization of charges.

I understand that I am responsible for the payment of any charges for dental services rendered to the above child. All services and their cost will be discussed with me before such services are rendered.

Signature_____

Date_____ Relationship _____

E-Mail: _____

William J. Heimann, D.D.S.
1526 W. Glendale Avenue, Suite 103
Phoenix, Arizona 85021-8576
(602)864-1080 Fax (602)864-7036

PATIENT'S HEALTH HISTORY

Your answers to these questions are of great value to us
in having a better understanding of your child.

	CHECK ONE Yes	No
Is your child in good health? If no, please explain_____	___	___
_____		
Has your child had any history of: epilepsy; heart trouble; allergies; diabetes;	___	___
asthma; kidney, liver or thyroid disorders; mental retardation; prolonged bleeding or hepatitis? (If yes, underline condition)		
Which childhood diseases has your child had? (Please underline) Measles, Mumps, Chicken Pox, Whooping Cough, Other_____		
Has your child ever had a blood transfusion, been given blood products, or been tested for HIV/AIDS?	___	___
Has your child had a history of earaches, sore throats or tonsillitis?	___	___
Has your child been given oxygen, been under general anesthesia, or had any surgical procedures? If yes, when?	___	___
Has your child had any unfavorable reactions to any medicine or drugs, including antibiotics and local anesthesia? If yes, please explain	___	___
_____		
Is your child allergic to any food or medication? If yes, what?	___	___
_____		
Has your child ever had a sensitivity to latex products?	___	___
Does your child have any special problems we should be aware of?	___	___
Date of last dental care _____		
Has your child any history of thumb sucking, finger or lip sucking or nail biting?	___	___
Has your child had a history of missing teeth? _____	___	___
How do you think your child will respond to the dentist? _____		
Has your child had any unfavorable experience in a medical or dental office?	___	___
(If yes, please explain) _____		
Is your child taking any medication?	___	___
(If yes, what kind and reason for taking)_____		
What is your child interested in? (pets, hobbies, etc.) _____	___	___

Please add anything you feel will help us in understanding and treating your child.

_____

_____

William J. Heimann D.D.S.
1526 W. Glendale #103
Phoenix, AZ 85021

NOTICE OF PRIVACY

This notice describes how dental/medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully and sign below.

I understand that as part of my dental care, this organization originates and maintains dental records describing my health history, dental treatment, dental treatment plan and any plans for further care or treatment. I understand that this information serves as:

*A basis for planning my dental care and treatment
*A means of communication among the dental care professionals who contribute to my care.
*A source of information for applying my diagnosis information to my bill.
*Means by which a third-party payer can verify that services billed were actually provided.
*And a tool for routine dental care operations such as assessing quality and reviewing the competence of dental care professionals.

I understand the Notice of Privacy that has been given to me from Dr. William J. Heimann.

Signed this _____day of_____, 20_____
Printed patient name:_____
Relationship to patient:_____

Signature:_____

I would like the following person(s) to have access to my dental/medical information

_____ _____
name relationship to patient

_____ _____
name relationship to patient