www.ZPD4KIDS.com

Consent to Communicate to Non-Parent

It is Patient/Parent's request that the practice communicate with a family representative on behalf of the parents/guardians

Patient Name (print):____

Patient Name (print):____

The following person(s) may attend visits and receive information regarding: check all that apply

◯ Treatment scheduled to be performed

◯ Future treatment planned for the above named child or children

Person Authorized______________________________________Relationship____________

Person Authorized______________________________________Relationship____________

◯ This authorization only valid for ____________________________Date(s) of Service

◯ This authorization valid for any dates of service

Signature of Patient/Parent:________________________________ Date:____________

Relationship to the Patient:____

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55 Brendon Way, Suite 500 Zionsville, IN 46077 317.873.4186

Dr. Melissa McHenry DDS, MSD
55 Brendon Way, Suite 500
Zionsville, IN 46077
(317)873-4186

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

For the office of
ZIONSVILLE PEDIATRIC DENTISTRY
"You may refuse to sign this acknowledgement"

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

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

____

____

____

____

Dr. Melissa McHenry DDS, MSD
55 Brendon Way, Suite 500
Zionsville, IN 46077
(317)873-4186

Medical History Update

Today's Date:. _______________
Patient Name:. _________________________________ Patients Date of Birth:. ____________________
Mother's Name: ________________________________ Father's Name:. ___________________________
Mother's Phone: ________________________________ Father's Phone: ___________________________
Email Address(es): ____
Address:____
Dental Insurance Name: __________________________________ ID#/SS#. _______________________
Insured's Name:. ________________________________ Employer:. ________________________________

Are there any concerns that you would like to have addressed at today's appointment?

____

Have there been any changes in your child's health In the last 6 months?

____

Are your child's immunizations up to date? ____
Is your child currently under the care of a physician for medical problems? If so, please explain.

____

Does your child have a heart condition? If so, does your physician require an antibiotic prior to dental treatment?____
Does your child have any allergies to medication, food, latex, metal or acrylic?

____

Does your child have a history of diabetes, asthma, kidney or liver difficulties and/or bleeding?

____

Has your child had any accidents involving the head, face or teeth since their last visit?

____

List any medications that your child is taking.

____

Has your child recently been diagnosed with any disabilities or behavioral issues?

____

Does your child use water that is fluoridated or take any fluoride supplements? Y or N

Parents Signature: ____Date:___________________

Please provide the front desk with your current Insurance card. THANK YOU!!!

2.22.3 Agreement to Receive Electronic Communication

Patient Name: ________________________________ Date of Birth:______________
Patient Name: ________________________________ Date of Birth:______________
Patient Name: ________________________________ Date of Birth:______________
Patient Name: ________________________________ Date of Birth:______________

I agree that the dental practice may communicate with me electronically at the email or text address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling:

Privacy Official: Janice VanGorder
Address: ZIONSVILLE PEDIATRIC DENTISTRY
55 Brendon Way, Suite 500, Zionsville, IN 46077
Telephone Number: **317-873-4186**

Email Address (PLEASE PRINT CLEARLY):
______________________________@________________

Cell Phone______________________________________

Patient Signature:____________________________

Date:______________

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