

Welcome

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

1 Tell Us about Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ___/___/___ Child's Age: _____

Nickname: _____ Male Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____) _____ SS #: _____

Child's Home Address: _____
Apt / Condo # _____

City State Zip

2 General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No

Whom may we Thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date: _____

Dentist's Phone #: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____
City State Zip

3 Parent's Information

Person Responsible for Account: _____ Parent's Marital Status Single Married Partnered Widowed Divorced Separated

Father Step Father Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
City State Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

Mother Step Mother Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____
City State Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

4 Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits other wise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist 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.

Signature of Parent or Guardian _____

Date _____

Continued on Back



Dental History



Medical History

Why did you bring the child to the dentist today? _____

Has the child ever taken Fosamax or any other bisphosphonate? If so, when? Yes No

Is the child currently in pain? Yes No

Does the child require antibiotics before dental treatment? Yes No

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health: Good Fair Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: _____

Aside from items listed, please list all drugs/things that the child is allergic to: _____

Yes No Latex Yes No Metals/Nickel Yes No Plastic

Has the child experienced the following medical problems?

- | | | | |
|---|--------------------------------|---|-----------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Abnormal Bleeding / Hemophilia | <input type="checkbox"/> Y <input type="checkbox"/> N | Heart Murmur |
| <input type="checkbox"/> Y <input type="checkbox"/> N | ADD/ADHD | <input type="checkbox"/> Y <input type="checkbox"/> N | Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N | AIDS/HIV+ | <input type="checkbox"/> Y <input type="checkbox"/> N | High Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N | Hives |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Any Hospital Stays/Operations? | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Artificial Bones/Joints/Valves | <input type="checkbox"/> Y <input type="checkbox"/> N | Liver Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N | Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N | Lupus |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Chicken Pox | <input type="checkbox"/> Y <input type="checkbox"/> N | Measles |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N | Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Convulsions | <input type="checkbox"/> Y <input type="checkbox"/> N | Mononucleosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N | Prosthetics |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N | Rheumatic Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Exposed to HIV, but Neg. | <input type="checkbox"/> Y <input type="checkbox"/> N | Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Handicaps/Disabilities | <input type="checkbox"/> Y <input type="checkbox"/> N | Skin Rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Hearing Impairment | <input type="checkbox"/> Y <input type="checkbox"/> N | Tuberculosis (TB) |

Are the child's immunizations current? Yes No

Anything you would like to discuss with the Doctor in private? Yes No

Please discuss any serious medical problems the child experiences/ed: _____

Does/did the child experience any of the following?

- | | | | |
|---|--------------------------|---|-----------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Breast Fed | <input type="checkbox"/> Y <input type="checkbox"/> N | Nursing Bottle Habits |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Chewing on Objects | <input type="checkbox"/> Y <input type="checkbox"/> N | Speech Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Clenching/Grinding Teeth | <input type="checkbox"/> Y <input type="checkbox"/> N | Thumb/Finger Sucking |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Lip Sucking/Biting | <input type="checkbox"/> Y <input type="checkbox"/> N | Tongue/Cheek Biting |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Mouth Breather | <input type="checkbox"/> Y <input type="checkbox"/> N | Tongue Thrust |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Nail Biting | <input type="checkbox"/> Y <input type="checkbox"/> N | Used Pacifier |

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____ Date _____



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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. _____

Dentist's Comments: _____ Signature of Dentist _____ Date _____

Medical History Update

Has there been any change in your child's health status since their last visit? Y N
If Yes, please explain. _____

Parent/Guardian Signature _____ Date _____

Has there been any change in your child's health status since their last visit? Y N
If Yes, please explain. _____

Dentist Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain right regarding my protected health information. I understand this information can and will be used for:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it's NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand I may request in writing that you restrict how many private information is used or disclosed to carry treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's acknowledgement on this notice of PRIVACY PRACTICES ACKNOWLEDGEMENT but was unable to do so as document below:

Date: _____

Initials: _____

Reason: _____

