

Child's Name _____ Nickname _____

Date of Birth _____ Male _____ Female _____ Weight _____ Today's Date _____ School _____

Father's Name _____ Name and Complete Address of Nearest Relative Not Living With You: _____

Mother's Name _____

Home Address _____

Home Phone _____ Relationship To Relative _____

Referred By: _____ Home Phone _____

Medical History

1. Child's Physician or Group Practice _____ Physician's Phone # _____

2. Place of Birth _____

3. Any problems or medications during pregnancy? _____

4. Is your child in good health now? _____

5. Taking any medications? _____ If so, what drug (s) and for what reason? _____

6. Names and ages of siblings: _____

7. Has your child ever had any of the following:

Heart disease or defects _____	Autism/ADHD _____	Sight Problems _____
Heart Murmur _____	Asthma/Breathing Difficulties _____	Emotional Problems _____
Rheumatic Fever _____	Anemia or Blood Disorders _____	Cleft Lip or Palate _____
Diabetes _____	Bleeding Difficulties _____	Intellectual Disability _____
Kidney Disease _____	Hepatitis or Liver Disease _____	Cerebral Palsy _____
Convulsions _____	Dizziness or Fainting _____	Birth Defects _____
Latex Allergies _____	Any other Illness _____	Receive any blood by-products / Transfusions or whole blood _____

8. Is your child allergic to any food or drugs: (Penicillin, Novocain, aspirin, ect.) _____

9. Has your child ever been warned by a physician against taking any specific drug or medication? _____
If so, please explain _____

10. Has your child ever been hospitalized for any reason? _____ When? _____
For what reason? _____

DENTAL HISTORY

1. Is this your child's first visit to a dentist? _____ If not, date of last visit _____

2. Is your child having any dental problems? _____ Please explain _____

3. Age at which first tooth erupted _____

4. Did your child ever sleep with a bottle? _____ What did the bottle contain? _____
At what age did he or she stop? _____

5. Does your child brush his (her) own teeth? _____ If not, by whom _____ When? _____

6. Does your child have any speech difficulties? _____

7. What habits does your child have which might affect the teeth or mouth? Mouth breather _____ Clenching or grinding or
teeth _____ Thumb sucking _____ Sucks finger _____ Other _____

8. Has your child had any dental injuries? Provide details _____

9. Has your child had fluoride supplements at home? _____ Is your water fluoridated? _____

10. Dietary Summary (types and frequency of sweets) _____

11. Significant dental history in any family members (i.e. missing teeth; extra teeth; soft tissue problems; ect.) _____

12. Please add any other information or comments which you feel we should know about your child _____

)

RESPONSIBLE PARTY INFORMATION

Name _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

e-mail address _____ With whom does the patient live _____ both _____ Mother _____ Father _____ Other _____

Social Security # _____ Birth date _____ Relationship to Patient _____

Employer _____ Occupation _____

Employer Address _____
Street City State Zip

Spouse's Name _____ Relationship to Patient _____
Last First Middle

Social Security # _____ Birth date _____ Work Phone _____

Employer _____ Occupation _____

DENTAL INSURANCE INFORMATION

Insured's Name _____ Social Security # _____

Insurance Company Name _____ Group # _____

Insurance Company Address _____

Insurance Company Phone # _____

Insured's Employer _____

Do You Have Additional Dental Insurance Coverage? Yes No If Yes, Please Complete the Following:

Insured's Name _____ Social Security # _____

Insurance Company Name _____ Group # _____

Insurance Company Address _____

Insured's Employer _____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. (If payable to the Insured, then payment is due at the time services are rendered) I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services the day they are rendered on my behalf and my dependents.

X _____ Date _____
SIGNATURE OF PARENT OR GUARDIAN

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your **Notice of Privacy Practices**, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ Date: _____