Child Health/Dental History Form

ADA American Dental Association®
America's leading advocate for oral health

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ❑ F ❑	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

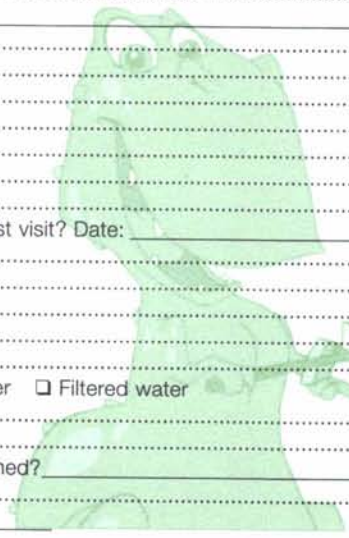
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician_____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. ❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. ❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. ❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. ❑	❑
6.	Has the child ever been hospitalized?	6. ❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	7. ❑	❑
8.	Has the child ever received a general anesthetic?	8. ❑	❑
9.	Does the child have any inherited problems?	9. ❑	❑
10.	Does the child have any speech difficulties?	10. ❑	❑
11.	Has the child ever had a blood transfusion?	11. ❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	12. ❑	❑
13.	Does the child experience excessive bleeding when cut?	13. ❑	❑
14.	Is the child currently being treated for any illnesses?	14. ❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. ❑	❑
16.	Has the child had any problem with dental treatment in the past?	16. ❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	17. ❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	18. ❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	19. ❑	❑
20.	Has the child had any orthodontic treatment?	20. ❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	22. ❑	❑
23.	**Is fluoride toothpaste used?**	23. ❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. ❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	25. ❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	27. ❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

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Our Office Policy

General

Thank you for choosing our practice as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete our information and insurance form before seeing the doctor. FULL PAYMENT IS DUE AT TIME OF SERVICE. UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE PRIOR TO APPOINTMENT.

We accept Cash, Checks, Visa, MasterCard and Care Credit.

Regarding Insurance

Fees are estimates only, and are valid for 30 days from the date shown above and are subject to revision. Treatment could be altered if your dental needs change. The patient will be notified of any change(s) in treatment.

Usual and Customary Rates

Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to be approved; Visa/MasterCard or payment by cash or check at time of service has been verified.

Missed Appointments

Unless canceled, at least 2 business days (Monday-Thursday) in advance, our policy is to charge for missed appointments at the rate of $50.00 to the full amount of the scheduled visit. Please help us serve you better by keeping scheduled appointments.

Consent

I understand and agree to this Financial Policy

Patient Name (please print) _____

Patient/Guardian Signature _____ Date_____

Doctor Signature _____ Date _____

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize the professional office of my dentist to release health information identifying me [Including if applicable, information about HIV infection or AIDS, information about substance Abuse treatment, and information about mental health services] under the following terms and conditions:

1. Detailed description of the information to be released: Completed, existing, and proposed dental treatment, Dental x-ray information, Medical history, Treatment referral information, Insurance authorization and benefit breakdown, Account information, such as balances due, amounts paid, and insurance coverage

2. To whom may the information be released: Professional associates, partners and referring doctors, third party billing entities and insurance carriers

3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual): To enable dental services to be provided

4. Expiration date or event relating to the individual or purpose for the release: Term shall end upon termination of professional-patient relationship.

5. Restrictions on disclosure of my PHI as follows:
It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.
If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

Send this note to the office contact person listed at the top of this form.
When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Name (please print): _____

Patient or Guardian/representative Signature: _____ Date: _____

Doctor Signature: _____ Date: _____