HEALTH HISTORY

For your convenience… Print this form, complete all information, and bring it with you on your first visit to our office. The parent or guardian who accompanies your child is responsible for payment at the time of service.

TELL US ABOUT YOUR CHILD

Name______________________________

Nickname_________________________ M / F

DOB ______________ Age ______________

Home Address _________________________

____

To detect decay and prevent decay, I authorize my child to have:

X-rays Y / N **Fluoride** Y / N **Sealants** Y / N

***If you have any questions about the above procedures, please let us know.**

PARENT #1 INFORMATION

Name ______________________________

Relationship to Patient ________________________

DOB ______________ SSN ______________

Employer ___________________________

__________ __________ __________

Wireless Contact # Work Contact # Second Contact #

Email ______________________________

Do you have legal custody of this child? Y / N

Marital Status: Single / Married / Separated / Widowed / Divorced

PARENT #2 INFORMATION

Name ______________________________

Relationship to Patient ________________________

DOB ______________ SSN ______________

Employer ___________________________

__________ __________ __________

Wireless Contact # Work Contact # Second Contact #

Email ______________________________

Do you have legal custody of this child? Y / N

Marital Status: Single / Married / Separated / Widowed / Divorced

EMERGENCY ADDITIONAL CONTACT

Phone contact for someone outside of your home.

Name ______________________________

Contact Number ________________________

WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name______________________________

Relationship to Patient ________________________

Do you have legal custody of this child? Y / N

INSURANCE

PRIMARY

____

Insurance Company Name

____

Policy Owner's Name

SECONDARY

____

Insurance Company Name

____

Policy Owner's Name

ADDITIONAL QUESTIONS

What is the purpose of today's visit? ____________________

____

____

we ♥ SMiLES

DENTAL HISTORY

Has your child seen a dentist? Y / N

How long has it been since the last visit to a dentist?___________________

Were any x-rays taken at previous dental visits? Y / N

Previous dentist's name: ___________________

Have there been any past injuries to the teeth, face or mouth? Y / N

If yes, please explain: ___________________

Does your child have any pain? Y / N

Does your child have any of the following habits? **(Please indicate with an X)**

	Lip sucking/biting		Using a bottle or sippy cup
	Nursing		Nail biting
	Thumb/finger sucking		Going to bed with a bottle or sippy cup

Has your child ever had a serious or difficult problem associated with previous dental work? If yes, please explain: ___________________

(Please indicate with an X)

	Is your child's water fluoridated?		Any feeding problems?
	Is your child taking fluoride supplements?		Are your child's teeth flossed every day?
	Has your child ever had any pain or tenderness in his/her jaw/joint (TMJ/TMD)?		Does your child brush his/her teeth daily?

HEALTH HISTORY

Has your child had a history or difficulty with any of the following:

(Please indicate with an X)

	Heart		Brain Injury or Past Trauma
	Asthma		Bone Disorder
	Diabetes		Bleeding Disorder
	Seizures		Cerebral Palsy
	Medication Allergy		Liver Problems
	Delayed Development		Premature Birth
	Emotional / Behavioral		Cancer
	Autism		Immune Disorder / Hepatitis / HIV / AIDS
	ADD / ADHD		
	Speech Disorder		Fainting
	Hearing		Tuberculosis
	Rheumatic Fever		Anemia
	Nosebleeds		Kidney
	Snoring / Sleep Apnea		Pregnancy
	Bruising		

*Please provide us with any other conditions or information that may be important to your child's dental care.

☐ **Check box if your child has no medical conditions.**

HEALTH HISTORY (CONT.)

Please discuss any serious medical problems your child has had: ___________________

Please list all medications your child is currently taking: ___________________

Please list all medications, food your child is allergic to and any sensitivities to metals: ___________________

Has patient had first hand, second hand or third hand exposure to tobacco, alcohol or drugs? Y / N If yes, please explain: ___________________

Is there anything else you would like us to know? ___________________

Child's Physician

Contact Number

Is your child currently under the care of a physician? Y / N

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

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

Who may we thank for referring you to our office? ___________________

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of 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

Date   Relationship to Child

FOR OFFICE USE ONLY

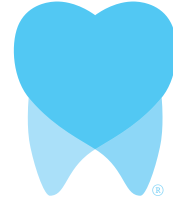
I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials   Date

Doctor's Comments ___________________

we ♥ SMiLES

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION



SMiLES 4 KeePS
PEDIATRIC DENTISTRY

PURPOSE, NOTICE OF PRIVACY PRACTICES, RIGHT TO REVOKE, AND DENIED INSURANCE

Patient Name: ____ DOB: ______________________

PURPOSE OF CONSENT

By signing this form, you consent to our use and disclosure of your child's health information to carry out treatment, payment activities, and healthcare options.

NOTICE OF PRIVACY PRACTICES

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosure we may make of your child's protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's protected health information that we maintain.

RIGHT TO REVOKE

You will have the right to revoke the Consent at any time by giving us written notice of your revocation submitted to the receptionist in our office. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat your child or to continue treating your child if you revoke this consent.

I, ________________________________ (name), as the ____________________________ (relationship to patient) of the above named patient, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form. I am giving consent to your use and disclosure of my child's protected health information to carry our treatment, payment activities, and healthcare options.

DENIED INSURANCE

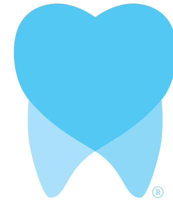
Insurance claims may be denied for a variety of reasons. I hereby give permission for Smiles 4 Keeps representatives to contact my insurer on my behalf in order to determine the reason for denied claims and appeal the decision when possible.

____ ________________
Signature Date

we ♥ SMiLES

CONS-USE-DISC/5-19

ALTERNATE SIGNERS FOR CONSENT



SMiLES 4 KeePS
PEDIATRIC DENTISTRY

Date: ___________________

I ____, hereby authorize the following persons to accompany
Name of Parent or Guardian

____
Name of Child/Children

to their scheduled appointment and offer written consent on my behalf for recommended treatment. Such treatment may include dental examination, prophylaxis, restorations, crowns, x-rays, pulpal therapy, space maintainers, sealants, extractions as well as, but not limited to Hydroxyzine, local anesthesia, Nitrous Oxide, Demerol, any rescue medications or interventions, and the use of Pedi-Wrap (for patient safety). I am aware that my child's treatment may change and authorize the amended treatment to be performed.

OPTION A

I hereby authorize consent for all future treatment ________________. Please provide a cell phone # ________________.
Initials

***If there are changes to the treatment the staff will inform the authorized signers and get consent and signature prior to making necessary changes.**

Name of Parent or Guardian (Print)	Signature of Parent or Guardian
Names of Authorized Signers (Print)	Relationship to Child
Names of Authorized Signers (Print)	Relationship to Child
Names of Authorized Signers (Print)	Relationship to Child
Witness	

OPTION B

I hereby authorize the treatment presented on _________________ for this treatment plan only. _________________
Date Initials

***I understand that this authorization may be revoked at any time in writing.**