DENTISTRY FOR CHILDREN

About Your Child

Child's Name (First, Middle, Last)

Name child prefers to be called

☐ Male ☐ Female

Date of birth

School (if applicable)

Reason for Visit:

Child's Hobbies:

Names of other children:

Referred by:

Dental History

Is this your child's first dental visit? ☐ Yes ☐ No

Previous Dentist

City & State

Date and Nature of Last Visit

Any history of injuries to your child's teeth or jaws? ☐ Yes ☐ No

When & how?

Child finished nursing or bottle-feeding at age:

Habits (check):

Thumb/finger sucking:	☐ now	☐ in past
Pacifier:	☐ now	☐ in past
Teeth grinding or clenching:	☐ now	☐ in past
	☐ none	

Has your child experienced any unfavorable reaction to previous medical or dental care? ☐ yes ☐ no

If yes, please explain:

How do you think your child will respond to dental treatment?

Medical History

Physician's Name

Phone Number

Emergency Contact Name

Relationship

Address

City & State

Phone Number

Is your child currently under the care of a physician for a specific medical problem? ☐ Yes ☐ No

If yes, what?

Is your child currently taking any prescription or over-the-counter medications? ☐ Yes ☐ No

If yes, what?

Has your child had a history of taking any medications frequently? ☐ Yes ☐ No

If yes, what?

Does your child take prescription fluoride? ☐ Yes ☐ No

Is your child allergic to any medication? ☐ Yes ☐ No

If yes, what?

What was the reaction?

Does your child have any allergies to latex, dyes or metals? ☐ Yes ☐ No

If yes, what?

What was the reaction?

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No

For what?

Has any member of your family, including your child, had a problem with general anesthetic? ☐ Yes ☐ No

If yes, describe:

Are your child's immunizations up to date? ☐ Yes ☐ No

Have you ever been told that your child requires antibiotics prior to dental treatment because of a heart defect or any other medical condition? ☐ Yes ☐ No

Medical History (Continued)

Has your child been diagnosed as having any of the following conditions? (Please check yes or no for each):

Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Ear problems
☐	☐	Anemia	☐	☐	Eye problems
☐	☐	Arthritis	☐	☐	Excessive gagging
☐	☐	Asthma	☐	☐	Fainting or dizziness
☐	☐	Autism	☐	☐	Fever blisters
☐	☐	Bladder conditions	☐	☐	Growth problems
☐	☐	Blood disease	☐	☐	Hearing impairment
☐	☐	Blood transfusions	☐	☐	Heart murmur / defect
☐	☐	Birth defects	☐	☐	Hemophilia
☐	☐	Bone or joint problems	☐	☐	Hepatitis
☐	☐	Brain injury	☐	☐	High blood pressure
☐	☐	Bruises easily	☐	☐	Hyperactivity / ADHD
☐	☐	Cancer or malignancies	☐	☐	Kidney disease
☐	☐	Cerebral palsy	☐	☐	Liver disease
☐	☐	Chemotherapy or radiation	☐	☐	Neurological problems
☐	☐	Child abuse	☐	☐	Nutritional deficiency
☐	☐	Chronic infections	☐	☐	Pain in jaw joints
☐	☐	Chronic headache	☐	☐	Premature birth
☐	☐	Cleft lip / palate	☐	☐	Psychiatric care
☐	☐	Congenital heart disease	☐	☐	Respiratory disease
☐	☐	Convulsions or seizures	☐	☐	Rheumatic fever
☐	☐	Developmental delay	☐	☐	Sickle cell disease
☐	☐	Diabetes	☐	☐	Speech disorder
			☐	☐	Syndrome: _____
☐	☐	Do you wish to speak with the doctor privately about any special concern (medical concerns or otherwise)?	☐	☐	Other: _____

Insurance

Primary Dental Insurance Company _____ Member ID # _____

Address _____ Phone _____

Policy Holder's Name _____ Relationship to Patient _____

Secondary Dental Insurance Company _____ Member ID # _____

Address _____ Phone _____

Policy Holder's Name _____ Relationship to Patient _____

Medical Insurance Company _____ Member ID # _____

Address _____ Phone _____

Responsible Party

(Must be fully completed to accept insurance assignment)

Mother's Full Name _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____

Home Phone _____ Business or Cell Phone _____

Employer _____ Occupation _____

Email Address _____

Father's Full Name _____

Address _____

City _____ State _____ Zip _____

Social Security # _____ Date of Birth _____

Home Phone _____ Business or Cell Phone _____

Employer _____ Occupation _____

Email Address _____

Authorization and Consent

I understand that I am responsible for all charges incurred by me or my family and that payment is due at the time of service. I hereby authorize payment directly to Dentistry for Children from insurance companies listed above. I agree to payment of any co-pays, deductibles, and uncovered services or amounts. I authorize the release of any information necessary to process insurance claims. If my account requires servicing for collection, I understand that I will be liable for fees and 18% interest in addition to my outstanding balance.

I give the doctor permission to use such measures as deemed necessary in her professional judgment to render diagnosis and treatment for my child. I have given an accurate report of my child's dental and medical histories.

Signature _____ Date _____

Relationship to Child _____

Reviewing Doctor's Signature _____ Date _____

This notice describes how healthcare information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our commitment at Dentistry for Children is to serve our patients with professionalism and care, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your healthcare needs, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing service.
- During healthcare operations, we may need to collaborate with other providers (ex. your child's physician or treating orthodontist).

We at Dentistry for Children are committed to obeying all federal, state and local laws and regulations regarding Privacy Practices. If any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided for by the law.

If you have any questions or comments regarding your Protected Health Information, feel free to contact our office at (303) 798-4400.

☐ I have read and understand the above Notice of Privacy Practices

Patient Name: _____

Signed (Parent or Legal Guardian): _____

Date: _____

* You may refuse to sign this acknowledgement

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