



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 ever 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 use 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	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	Ear problems
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Eye problems
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Excessive gagging
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Fever blisters
<input type="checkbox"/>	<input type="checkbox"/>	Bladder conditions	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease
<input type="checkbox"/>	<input type="checkbox"/>	Blood disorder	<input type="checkbox"/>	<input type="checkbox"/>	Growth problems
<input type="checkbox"/>	<input type="checkbox"/>	Blood transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment
<input type="checkbox"/>	<input type="checkbox"/>	Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur / defect
<input type="checkbox"/>	<input type="checkbox"/>	Bone or joint problems	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia
<input type="checkbox"/>	<input type="checkbox"/>	Brain injury	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Bruises easily	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Cancer or malignancies	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity / ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral palsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy or radiation	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse	<input type="checkbox"/>	<input type="checkbox"/>	Neurological problems
<input type="checkbox"/>	<input type="checkbox"/>	Chronic infections	<input type="checkbox"/>	<input type="checkbox"/>	Nutritional deficiency
<input type="checkbox"/>	<input type="checkbox"/>	Chronic headache	<input type="checkbox"/>	<input type="checkbox"/>	Pain in jaw joints
<input type="checkbox"/>	<input type="checkbox"/>	Cleft lip / palate	<input type="checkbox"/>	<input type="checkbox"/>	Premature birth
<input type="checkbox"/>	<input type="checkbox"/>	Congenital heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric disorder
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory disease
<input type="checkbox"/>	<input type="checkbox"/>	Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	Sensory issues
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell disease
			<input type="checkbox"/>	<input type="checkbox"/>	Speech disorder
<input type="checkbox"/>	<input type="checkbox"/>	Do you wish to speak with the doctor privately about any special concern (medical concerns or otherwise)?	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease
			<input type="checkbox"/>	<input type="checkbox"/>	Syndrome: _____
			<input type="checkbox"/>	<input type="checkbox"/>	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)

_____ Guardian Name	_____ Relationship	
_____ Address		
_____ City	_____ State	_____ Zip
_____ Social Security #		_____ Date of Birth
_____ Home Phone		_____ Business or Cell Phone
_____ Employer		_____ Occupation
_____ Email Address		
_____ Guardian Name	_____ Relationship	
_____ 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