PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

Patient Name ______________________________ SS# ________________ Date ________________

Age ____ Date of Birth ____________ Sex ____ Race ________ Parent/Guardian ________________

Cell Phone # ________________ Work # ________________ e-mail: ________________

Address ______________________________ City ________________ State ______ Zip ______

Name of Child's Physician ______________________________ Date last seen ________________

In an emergency, please write name & phone # of someone **other than a person who lives with you**:

______________________________ Phone # ________________

AUTHORIZATION & FINANCIAL RESPONSIBILITY (NOT AN INSURANCE COMPANY):

***You are responsible for what your insurance does not cover**

Person responsible for child's financial support: ________________ DOB: ________ SS# ________________

Address ______________________________ Phone # ________________

Employer ______________________________ Phone # ________________

Is your child covered by a dental insurance plan? Yes ______ No ______

Insured's Name ______________________________ DOB: ____________ SS# ________________

Name of Insurance Company ________________ Policy # ________________ Group # ____________

Has your child received care under this plan? Yes ______ No ______

Is your child being treated by a physician at this time? Yes No

If yes, why? ____

Has your child ever been a patient in a hospital? Yes No

If yes, why? ____

Has your child ever received general anesthetic or sedation? Yes No

If yes, when? ____

Is your child allergic to anything? (food or medicine) Yes No

If yes, what? ____

Is your child taking ANY medications at this time? Yes No

If yes, what? ____

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Has your child ever been seen by a dentist before: Yes ______ No ______ Xrays? Yes ______ No ______

Date last seen ________________ Dentist's Name ______________________________

What is the primary reason for your visit today? ______________________________

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PLEASE SEE OTHER SIDE

ORGANS & SYSTEMS:

Does your child currently have or has had treatment for any of the following?

PLEAST CHECK YES OR NO FOR EACH:

Yes	No	Blood/Circulatory	Yes	No	Gastrointestinal/Stomach	Yes	No	Muscles
Yes	No	Blood Transfusion	Yes	No	Kidney or Bladder	Yes	No	Nervous System
Yes	No	Bones	Yes	No	Heart	Yes	No	Respiratory/Lungs
Yes	No	Endocrine Glands	Yes	No	Heart Murmur	Yes	No	Skin
Yes	No	Eyes/Ears/Nose/Throat	Yes	No	Liver	Yes	No	Tonsils/Adenoids

ILLNESSES:

Has your child ever been diagnosed as having any of the following conditions?

PLEASE CHECK YES OR NO FOR EACH:

Yes	No	AIDS	Yes	No	Eye Problems	Yes	No	Psychiatric Disorder
Yes	No	Anemia	Yes	No	Excessive Bleeding	Yes	No	Rheumatic Fever
Yes	No	Allergy	Yes	No	Fainting	Yes	No	Scarlet Fever
Yes	No	Arthritis	Yes	No	Hearing Loss	Yes	No	Scoliosis
Yes	No	Asthma	Yes	No	Heart Disease	Yes	No	Sickle Cell Anemia
Yes	No	Autism	Yes	No	Hemophilia	Yes	No	Sinus Problems
Yes	No	Brain Injury	Yes	No	Hepatitis Type _____	Yes	No	Snoring at night
Yes	No	Bronchitis	Yes	No	Jaundice	Yes	No	Sore Throat – frequent
Yes	No	Cancer	Yes	No	Leukemia	Yes	No	Spina Bifida
Yes	No	Cerebral Palsy	Yes	No	Measles	Yes	No	Syndrome __________
Yes	No	Chicken Pox	Yes	No	Intellectual disability	Yes	No	Tetanus
Yes	No	Cleft Lip/Palate	Yes	No	Mumps	Yes	No	Tuberculosis
Yes	No	Convulsions/Seizures	Yes	No	Mouth Breathing	Yes	No	Venereal Disease
Yes	No	Diabetes Type ______	Yes	No	Nutritional Deficiency	Yes	No	Whooping Cough
Yes	No	Diphtheria	Yes	No	Orthopedic Problems	Yes	No	Latex Allergy
Yes	No	Drug/Alcohol Abuse	Yes	No	Pneumonia	Yes	No	ADD/ADHD
Yes	No	Epilepsy	Yes	No	Pregnancy			

Is there anything else that you think we should know about your child?

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I understand that the office has a strict policy about missed appointments, and that I will be charged a missed appointment fee if I do not call at least one day before my appointment to cancel or reschedule it, and that after three missed appointments without a call to cancel or reschedule, the office will no longer see the patient. I also understand that if I have been seen within the last 6 months by any other dentist, I will be responsible for any charges my insurance doesn't cover at Dentistry for Children and Teens. I certify that I have read and understand the above questions/statements. I will not hold Dr. Davis and his associates or any member of his staff responsible for any errors or omissions I may have made on this form.

____
Signature of Parent or Legal Guardian

____
Relationship to Patient

____
Provider Signature

Dentistry for Children and Teens

15841 St. Clair Avenue E. Liverpool OH 43920 ● 265 Third Street Beaver PA 15009

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

The department of Health and Human Services has established a "Privacy Rule" to help ensure that personal health care information is protected for your privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for use and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect your privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about your treatment, payment, or healthcare operations, in order to provide health care that is in your best interest. This would include sending x-rays to another dentist, orthodontist, oral surgeon, etc. if your treatment needs dictate that. 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 post a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. For a copy of the contract you can contact us at 330-385-6201.

You may refuse to consent to the use of our disclosure of your or your child(ren)'s personal health information, but this must be in writing. Under this law, we have the right to refuse to treat the patient should you choose to refuse to disclose your Personal health Information. You may not revoke actions that have already been taken which relied on this or a previously signed contract.

You have the right to review our privacy notice, to request restrictions, and revoke consent for yourself or your child(ren) in writing after you have reviewed our privacy notice.

GIVING CONSENT:

I have reviewed, understand, and agree to this contract for myself or on behalf of my child(ren).

Printed name of Parent or Legal Guardian:____________________________

Signature of Parent or Legal Guardian:____________________________

Relationship to Patient:____________________________

Child(ren)'s Name(s):____________________________

Address:____________________________

Date:____________________________

REVOKE CONSENT:

I revoke my consent for the use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I also understand that Dentistry for Children and Teens may decline to treat or to continue to treat my child(ren) after I have revoked my consent on their behalf.

Printed name of Parent or Legal Guardian:____________________________

Signature of Parent or Legal Guardian:____________________________

Relationship to Patient:____________________________

Child(ren)'s Name(s):____________________________

Address:____________________________

Date:____________________________

Dentistry for Children and Teens Inc.

PEDIATRIC DENTISTRY CONSENT FOR DENTAL PROCEDURES

Patient(s) Name(s): ______________________________ **Date(s) of Birth:** __________

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps, extractions, etc., will be performed at a separate appointment after obtaining your permission.

State law requires that we obtain your written informed consent for any treatment given to your child as a legal minor.

1. I hereby authorize and direct the doctors / hygienists of Dentistry for Children and Teens Inc. assisted by dental auxiliaries of his or her choice, to perform upon my child the following dental treatments or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids, and nitrous oxide.

2. In general terms the dental procedures or operation may include:
   - A. Cleaning of the teeth and the application of topical fluoride.
   - B. Application of plastic “sealants” to the groves of the teeth.
   - C. Treatment of the diseased or injured teeth with dental restorations (fillings or caps/crowns). The caps/ crowns are normally white on the front teeth and silver on the backteeth.
   - D. Removal of severely decayed teeth that are unable to be restored.
   - E. Placement of space maintainers.
   - F. Informing of malposed (crooked) teeth and or oral developmental or growth abnormalities.
   - G. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1 1/2 to 3 hours. Allergic reactions are rare and your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child they are going to get a “shot”, we have a special way of informing them of this that prevents fear.
   - H. Use of nitrous oxide (laughing gas) is often used to help children relax and feel the injection less. This gas is placed over your child’s nose after an explanation is given. This gas is very safe when used in the concentration that will be used, and the nose piece, as with all treatment, will not be forced upon your child.
   - I. I fully understand that as with any procedure, that utilizes local or general anesthetic, there is a possibility of surgical and or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage, or death.

I further authorize the doctors / hygienists of Dentistry for Children and Teens Inc. to perform treatment as may be advisable to preserve the health and life of my child. I hereby state that I have read and understand this consent and that all questions about the procedures have been answered in a satisfactory manner. I also understand that I have a right to be provided with answers to questions which may arise during the course of my child’s treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it in writing.

____
Name of Parent/Guardian

____
Relationship to Patient

____
Signature of Parent/Guardian Date