HEALTH HISTORY

These questions are of great value in aiding us to a better understanding of your child.

A. Child's Full Name____ Nickname________________

B. Age_________ Birthdate_________ Sex_______ Weight___________

C. Home Phone (____)_________________

D. Do we treat others in your family? If so, list names__________________

E. Child's Physician____________________________ Date of last physical exam_______________

F. Family Dentist____

G. Has your child had a history of any of the following? (If yes, please circle and explain)

Blood Transfusion
Heart trouble
Heart murmur
Chemotherapy / Cancer
Allergies
Allergies to any Medications (Please list):
Diabetes
Asthma
Kidney or Liver involvement
Epilepsy or Seizures
Bleeding disorders
AIDS/ ARC
HIV positive
Communicable diseases
Prosthetic joints
Hepatitis
Has your child had a cerebral or spastic condition?
Is your child developmentally delayed?
Has your child experienced any unfavorable reaction from previous dental or medical care?

____

H. Please describe any current medical treatment, including drugs, pending surgery, recent injuries, or any other information we should be aware of that we have not yet discussed.

____

____

I. Reason for visit: ____

J. Referred by: ____

K. ________________________________ ____

(Signature) (Parent or Guardian) (Reviewed by) (Date)

GENERAL INFORMATION

A. Father's full name___________________________Cell Phone (___)__________ Home phone (___)___________
Address____________________________________Apt#________City_____________State______ Zip_________
Employed by______________________________________ Occupation______________________________________
How long?_________________________________ Birthdate _______________________________________
Business phone (___)________________________ Social Security # (SSN)____________________________
Driver's License #____________________________

B. Mother's full name___________________________Cell Phone (___)__________ Home phone (___)__________
Address__________________________________Apt#________City_____________State______ Zip__________
Employed by______________________________________ Occupation_____________________________________
How long?_______________________________ Birthdate ______________________________________
Business phone (___)______________________ Social Security # (SSN)____________________________
Driver's License #____________________________

C. Who is responsible for this account? ____
Address_____________________________________Apt#________City___________State_____Zip____________
Home phone (___)_____________________ Relationship to child_____________________________
Employer_______________________________________Business phone (___)__________________________
DOB__________________________

D. Is this child covered by dental insurance? _____If yes:

1. Insured's name____Carrier______________________
SSN #____________________________ Relationship to child__________________________
DOB________________________ Employer____________________________________
2. Insured's name____Carrier______________________
SSN #____________________________ Relationship to child__________________________
DOB________________________ Employer__________________________________

Patients having insurance coverage must also **make monthly payments** until the balance is cleared.

E. If we are unable to contact you, please list 2 other persons who may be able to reach you:

1.______________________________________ Phone# (___)__________________

2. ______________________________________ Phone # (___)_________________

F. CONSENT:
The undersigned hereby authorizes the Doctor to take x-rays and to use any diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs, and to perform treatment, therapy, or to prescribe any medication that may be needed.

____ Relationship to patient______________
(signed)

____
(date)

MEDICAID ☐ **Yes** ☐ **No**

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices form time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____

Signature: ____

Relationship to Patient: ____

Date: ___________________