

Account Information - Child

Patient Name: _____ Date: 08/04/11
Last, First MI (Preferred Name) Birthdate:

Address: _____
Street Apartment # City State Zip Code

Mother's Name: _____ Father's Name _____

Address _____ Address (if different): _____

Home Phone Number: _____ Home Phone Number (if different) _____

Mother Cell Phone _____ Father's Cell Phone _____

Mother's E-mail: _____ Father's Email _____

Names and ages of siblings: _____

Who may we thank for referring you to our practice? _____

May we mention you in our newsletter? Yes or No

Mother employed by _____ Social Security #: _____ Mother's birthdate _____

Mother's dental insurance company and address _____

Group # _____ Member ID # _____ Mother's Business Phone # _____

Father employed by _____ Social Security #: _____ Father's birthdate _____

Father's dental insurance company and address _____

Group # _____ Member ID # _____ Father's Business Phone # _____

Who is responsible for this account: _____ «Guar FName» «Guar LName»

Which dental insurance is primary for your child? _____

Rather than paying the insurance portion on the day that treatment is provided, I request all insurance benefits be paid directly to HealthPark. Signature _____

Consent for Services

I hereby authorize HealthPark Dentistry to speak with any health care practitioner who has treated, or is treating my child, about past or present medical or dental diagnosis, treatment or conditions. This authorization includes the releases of my dental and medical records to HealthPark Dentistry as s/he reasonably deems necessary. This authorization will remain valid until revoked by me in writing.

Previous dentist _____

Address _____

Phone _____ City _____ State _____

Physician's Name _____

Address _____

Phone _____ City _____ State _____

To the best of my knowledge, all of the answers are true and correct. If there is ever a change in my health history, or if my medicines change, I will inform this office at the next appointment without fail.

Signature of patient, parent, or guardian _____ date _____

Medical History

Dental treatment is part of your child's overall health care. That's why it's so important that we know about medications your child may be taking and any medical conditions that may affect your child's dental health. By completing it, you help us make sure that your child's treatment is not only dentally safe, but medically safe as well.

- Is your child in good health? Excellent Good Fair Poor
- Date of last physical exam? _____
- Has s/he been under the care of a physician in the last 2 years? Yes No
 If so, what for: _____
- Has s/he had any serious illnesses, operations or hospitalizations? Yes No
 If so, what for: _____

Do you have or have you ever had any of the following? Please check those that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Malignancies | <input type="checkbox"/> AIDS/HIV+ |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer, radiation/chemotherapy |
| <input type="checkbox"/> Heart Problems/pacemaker | <input type="checkbox"/> Hives or skin rash | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease |
| <input type="checkbox"/> Asthma/hay fever | <input type="checkbox"/> High or Low Blood Pressure | <input type="checkbox"/> Seizures/ Epilepsy or Tuberculosis |
| <input type="checkbox"/> Heart Valve damage | <input type="checkbox"/> Nervousness or apprehension | <input type="checkbox"/> Reaction to metal jewelry, nickel |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Blood disorders (anemia) | <input type="checkbox"/> Psychiatric care |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Sickle Cell disease |
| <input type="checkbox"/> Developmental/behavior
problem _____ | | <input type="checkbox"/> Headaches |

- Is there a history of cancer in your family _____
- Has your child ever had any unusual reactions or allergies to food, drugs or latex? _____
 If yes, please explain: _____

• Please list any drugs s/he has taken and the problems for which they are taken. (Including aspirin, herbs, etc.)

Medication _____ Taken For _____
Medication _____ Taken For _____
Medication _____ Taken For _____

- Has your child ever had any trouble with previous medical or dental treatment? Yes No
 If yes, please explain: _____

- Has your child ever had a blood transfusion? Yes No
- Is there anything else about your child's health I should know: _____

Signature of Dentist _____ Date _____

Date Updated _____ Date Updated _____ Date Updated _____ Date Updated _____

Dental History (Child)

1. What is the chief reason you've come to our office now? _____

2. When was the last time your child:
Went to the dentist: _____ Had a complete exam: _____
Had a full mouth x-rays: _____ Had teeth cleaned: _____
3. How would you describe the general condition of your child's teeth now? Poor Average Excellent
4. What would you like the general condition of your child's teeth to be? Poor Average Excellent
5. To reach this level of dental health, how much treatment will you need? Very little Some A lot
6. How do you feel about your child's past dental work? _____
7. What did you like most or least about how you were treated by your previous dentist? _____
8. Do you feel your child has required much dental care in the past? Yes No
9. If yes, has it been to replace previous dentistry or repair newly decayed areas: _____
10. Has your child had any teeth removed (extracted)? Yes No
11. When _____ Why _____
12. Are any areas causing your child discomfort (hot, cold, chewing, pressure)? _____
13. If you could change anything about your child's smile, what would it be? _____
14. Decay and gum disease potential for your child
15. Had a decay problem in the past? Yes No A dry mouth? Yes No
Bad breath? Often Occasionally No
Sugar (including soft drinks, candy) how many times during the day? _____
Regular dental cleanings? Yes No
How do you take care of your child's teeth? _____
Do gums bleed? _____
16. Are you experiencing any: Clenching Grinding of teeth Ringing in ears Headaches
 Earaches Neck/shoulder pain Clicking/popping jaw
17. Jaws feel tired when wakes up in the morning? Yes No
18. Any injury to your child's jaws? _____
19. Any teeth feel loose? _____
20. Is your child wearing any braces no yes- when placed _____
21. Have your parents had many dental problems? Few some many
22. Is it hard for your child to relax during dental treatment? No Slightly Moderately Extremely
23. What can we do to make your child more comfortable?
24. Are you deeply concerned about the finances to return your child's mouth to dental health? Yes No
25. So that we can get to know your child would you mark the activities your child most enjoys: Computer
Games Sports (which _____) Movies Music (type _____) Internet Other _____

Acknowledgement of Receipt of Notice of Privacy Practices

*you may refuse to sign this Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtainng acknowledgement
- Other (please specify)

