Chart #: _____
FOR OFFICE USE ONLY

Account Information - Child

Patient Name: _____ Date: _____
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_____

Legal Guardian (if not parent) _____

Names and ages of siblings: _____

How did you hear about HealthPark Dentistry? _____

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: _____
Which dental insurance is primary for your child? _____

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 deemed necessary, and records can be sent/received via email. 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

I authorize HealthPark Dentistry to use my and my child's name and photo in promotional materials such as newsletters, testimonials, and social media posts.

_____ _____
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:

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

Due to recent federal regulations we need your permission to receive a phone call, text, or mail message from us:

Yes: _____ No: _____

Annual consent update: Initials:_____ Date Updated _____ Initials: ____Date Updated _____

Initials: _____ Date Updated _____ Initials: _____ Date Updated: _____

Initials: _____ 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)

_____

_____

_____