Pediatric Dentistry

PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

Patient's Name _____ Nickname _____ Age _____
Last First Middle

Patient's Address _____ City _____ State _____ Zip _____

Date of Birth _____ Sex _____ School _____ Grade _____

Name of Patient's Physician _____ Phone # _____

Name of Family Pharmacy _____ Phone # _____

Patient's Social Security # _____

********** Email Address _____

Cell Phone # _____

Father's Name _____ Home Phone # _____ Birthdate _____
Last First Middle

Marital Status _____ If Married, Name of Spouse _____

Home Address _____ City _____ Zip _____

Father's Occupation _____ Business Phone # _____

Name of Employer _____ City _____

Name of Dental Insurance Company _____ Dental Ins. ID # _____ SS # _____

Address of Dental Insurance Company _____ City _____ State _____ Zip _____

Name of Medical Insurance Company _____ Group Plan # _____ MED Ins. ID # _____

Address of Medical Insurance Company _____ City _____ State _____ Zip _____

********** Email Address _____

Cell Phone # _____

Mother's Name _____ Home Phone # _____ Birthdate _____
Last First Middle

Marital Status _____ If Married, Name of Spouse _____

Home Address _____ City _____ Zip _____

Mother's Occupation _____ Business Phone # _____

Name of Employer _____ City _____

Name of Dental Insurance Company _____ Dental Ins. ID # _____ SS # _____

Address of Dental Insurance Company _____ City _____ State _____ Zip _____

Name of Medical Insurance Company _____ Group Plan # _____ MED Ins. ID # _____

Address of Medical Insurance Company _____ City _____ State _____ Zip _____

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Is your child covered by a dental insurance plan? Yes No Father's Mother's Step-Father Step-Mother Other

Is your child eligible for federal/state financial assistance? Yes No Medicaid (Title XIX) SSI EPSDT

Child's Welfare # _____

Whom may we thank for referring you? _____

HISTORY	YES	NO	COMMENTS
1. Is your child being treated by a physician at this time? If yes, why _____	☐	☐	
2. Has your child ever been a patient in a hospital? If yes, why _____	☐	☐	
3. Has your child ever received general anesthesia? If yes, when _____	☐	☐	
4. If your child allergic to anything? (medicine, food) _____	☐	☐	
5. Is your child taking any medicine at this time? If yes, what _____	☐	☐	
6. Has your child ever had a blood transfusion? _____	☐	☐	
7. Does your child smoke or use tobacco products? _____	☐	☐	
8. Has your child ever been seen by a dentist? Date last seen _____ _____ Name of dentist _____	☐	☐	
9. Were x-rays taken by referring dentist? _____	☐	☐	
10. Are these x-rays being mailed to us? _____	☐	☐	
11. Has your child ever received fluoride in any form? If yes, what _____	☐	☐	
12. Does your child, suck his/her thumb or fingers?	☐	☐	
13. Does your child suck a pacifier?	☐	☐	
14. Are your child's teeth brushed daily?	☐	☐	
15. What type of toothpaste does your child use? _____	☐	☐	
16. At what age did your child stop bottle/breast feeding? _____	☐	☐	

(over)

What was child's birth weight? ____ lbs. ____ oz. Was pregnancy normal? ___ Yes ___ No If no explain: _____

_____

Organs and Systems
Has this child ever had any treatment for any of the following? Please check yes or no:

Yes	No		Yes	No		Yes	No	
☐	☐	Blood - Circulatory	☐	☐	Gastrointestinal (stomach)	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Heart	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	Tonsils/Adenoids

Illness
Has this child ever been diagnosed as having any of the following conditions? Please check yes or no:

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS (Immunosuppresive Disorder)	☐	☐	Epilepsy	☐	☐	Polio
☐	☐	Anemia	☐	☐	Eye Problems	☐	☐	Pregnancy
☐	☐	Allergy	☐	☐	Excessive Bleeding Problem	☐	☐	Psychiatric Disorder
☐	☐	Arthritis	☐	☐	Fainting	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Hearing Loss	☐	☐	Scarlet Fever
☐	☐	Autism	☐	☐	Heart Disease	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Hemophilia	☐	☐	Sickle Cell Anemia
☐	☐	Bronchitis	☐	☐	Hepatitis - Type _____	☐	☐	Sinus Problems
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Snoring at Night
☐	☐	Cerebral Palsy	☐	☐	Leukemia	☐	☐	Sore Throats - Frequent
☐	☐	Chicken Pox	☐	☐	Measles	☐	☐	Spina Bifida
☐	☐	Cleft Lip/Palate	☐	☐	Mental Retardation	☐	☐	Syndrome _____
☐	☐	Convulsions/Seizures	☐	☐	Mumps	☐	☐	Tetanus
☐	☐	Diabetes	☐	☐	Mouth Breathing	☐	☐	Tuberculosis
☐	☐	Diphtheria	☐	☐	Nutritional Deficiency	☐	☐	Veneral Disease
☐	☐	Drug or Alcohol Abuse	☐	☐	Orthopedic Problems	☐	☐	Whooping Cough
			☐	☐	Pneumonia	☐	☐	Eating Disorder

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

_____

I certify that I have read and understand the above questions. I will not hold Dr. _____
or any member of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

_____

Signature of person completing form *Relationship to patient* *Date*

INSURANCE AUTHORIZATION

I, the undersigned insured, authorize this form to be used in lieu of my personal signature on my insurance submissions through the office of Dr._____ and permit this copy to remain on file. I also authorize the release of any information requested by my insurance carrier and authorize payment directly to the doctor. **Although I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier, I understand that I am responsible for my bill.**

Patient Name: _____

Signature of Insured (Primary) _____ Date _____

Signature of Insured (Secondary) _____ Date _____

MY CHILD IS COVERED BY MORE THAN ONE DENTAL INSURANCE PLAN. THE PRIMARY SUBSCRIBER IS:

NAME: _____

INSURANCE CO.: _____ INS. ID # _____

EMPLOYER: _____

THE SECONDARY SUBSCRIBER IS:

NAME: _____

INSURANCE CO.: _____ INS. ID # _____

EMPLOYER: _____

Reviewer _____ Date _____

Pediatric Dentistry of Central Iowa, P.C.

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB _____

I understand that as a part of healthcare, this organization originates and maintains health records describing health history, symptoms, examination and test results, diagnosis, treatment, and plans for future care and treatment.

I understand that the information serves as:

* A basis for planning care and treatment.
* A means of communication among the many healthcare professionals who contribute to care.
* A source of information for applying diagnosis and surgical information to the bill.
* A means by which a third-party payer can verify that services billed were actually provided.
* A tool for routine health care operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

* To object to the use of health information for directory purposes.
* To request restrictions as to how health information may be used or disclosed to carry out treatment, payment or healthcare operations- and that the organization is not required to agree to the restrictions requested.
* To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Signature of Parent or Legal Guardian _____

☐ I request the following restrictions to the use or disclosure of information for my child/children _____

☐ I hereby authorize the release of information to a non custodial parent or guardian.
Name of non-custodial parent: _____

Office Use only:

Accepted ___ Denied ___ Signature _____ Date _____

Pediatric Dentistry of Central Iowa, P.C.

You May Refuse to Sign This Acknowledgement

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

Print Name: _____

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 obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____