

# Pediatric Dentistry

## PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

Patient's Name \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_

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 \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Home Phone # \_\_\_\_\_ Birthdate \_\_\_\_\_

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 \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Home Phone # \_\_\_\_\_ Birthdate \_\_\_\_\_

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 _____	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has your child ever been a patient in a hospital? If yes, why _____	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has your child ever received general anesthesia? If yes, when _____	<input type="checkbox"/>	<input type="checkbox"/>	
4. If your child allergic to anything? (medicine, food) _____	<input type="checkbox"/>	<input type="checkbox"/>	
5. Is your child taking any medicine at this time? If yes, what _____	<input type="checkbox"/>	<input type="checkbox"/>	
6. Has your child ever had a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>	
7. Does your child smoke or use tobacco products? _____	<input type="checkbox"/>	<input type="checkbox"/>	
8. Has your child ever been seen by a dentist? Date last seen _____ Name of dentist _____	<input type="checkbox"/>	<input type="checkbox"/>	
9. Were x-rays taken by referring dentist? _____	<input type="checkbox"/>	<input type="checkbox"/>	
10. Are these x-rays being mailed to us? _____	<input type="checkbox"/>	<input type="checkbox"/>	
11. Has your child ever received fluoride in any form? If yes, what _____	<input type="checkbox"/>	<input type="checkbox"/>	
12. Does your child, suck his/her thumb or fingers? _____	<input type="checkbox"/>	<input type="checkbox"/>	
13. Does your child suck a pacifier? _____	<input type="checkbox"/>	<input type="checkbox"/>	
14. Are your child's teeth brushed daily? _____	<input type="checkbox"/>	<input type="checkbox"/>	
15. What type of toothpaste does your child use? _____	<input type="checkbox"/>	<input type="checkbox"/>	
16. At what age did your child stop bottle/breast feeding? _____	<input type="checkbox"/>	<input type="checkbox"/>	

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                       |                  |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Blood - Circulatory      | <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal (stomach) | <input type="checkbox"/> | <input type="checkbox"/> | Muscles          |
| <input type="checkbox"/> | <input type="checkbox"/> | Bones                    | <input type="checkbox"/> | <input type="checkbox"/> | Kidney - Bladder           | <input type="checkbox"/> | <input type="checkbox"/> | Nervous System   |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine Glands         | <input type="checkbox"/> | <input type="checkbox"/> | Heart                      | <input type="checkbox"/> | <input type="checkbox"/> | Skin             |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes, Ears, Nose, Throat | <input type="checkbox"/> | <input type="checkbox"/> | Liver                      | <input type="checkbox"/> | <input type="checkbox"/> | 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                       |                         |
|--------------------------|--------------------------|-----------------------------------|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|-------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS (Immunosuppressive Disorder) | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy                    | <input type="checkbox"/> | <input type="checkbox"/> | Polio                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia                            | <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems                | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy               |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergy                           | <input type="checkbox"/> | <input type="checkbox"/> | Excessive Bleeding Problem  | <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric Disorder    |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis                         | <input type="checkbox"/> | <input type="checkbox"/> | Fainting                    | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever         |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                            | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss                | <input type="checkbox"/> | <input type="checkbox"/> | Scarlet Fever           |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism                            | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease               | <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis               |
| <input type="checkbox"/> | <input type="checkbox"/> | Brain Injury                      | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia                  | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia      |
| <input type="checkbox"/> | <input type="checkbox"/> | Bronchitis                        | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis - Type _____      | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems          |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                            | <input type="checkbox"/> | <input type="checkbox"/> | Jaundice                    | <input type="checkbox"/> | <input type="checkbox"/> | Snoring at Night        |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy                    | <input type="checkbox"/> | <input type="checkbox"/> | Leukemia                    | <input type="checkbox"/> | <input type="checkbox"/> | Sore Throats - Frequent |
| <input type="checkbox"/> | <input type="checkbox"/> | Chicken Pox                       | <input type="checkbox"/> | <input type="checkbox"/> | Measles                     | <input type="checkbox"/> | <input type="checkbox"/> | Spina Bifida            |
| <input type="checkbox"/> | <input type="checkbox"/> | Cleft Lip/Palate                  | <input type="checkbox"/> | <input type="checkbox"/> | Intellectual Disability     | <input type="checkbox"/> | <input type="checkbox"/> | Syndrome _____          |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions/Seizures              | <input type="checkbox"/> | <input type="checkbox"/> | Nutritional Deficiency      | <input type="checkbox"/> | <input type="checkbox"/> | Tetanus                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes                          | <input type="checkbox"/> | <input type="checkbox"/> | Mumps                       | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis            |
| <input type="checkbox"/> | <input type="checkbox"/> | Diphtheria                        | <input type="checkbox"/> | <input type="checkbox"/> | Mouth Breathing Nutritional | <input type="checkbox"/> | <input type="checkbox"/> | Veneral Disease         |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug or Alcohol Abuse             | <input type="checkbox"/> | <input type="checkbox"/> | Deficiency Orthopedic       | <input type="checkbox"/> | <input type="checkbox"/> | Whooping Cough          |
|                          |                          |                                   | <input type="checkbox"/> | <input type="checkbox"/> | Problems Pneumonia          | <input type="checkbox"/> | <input type="checkbox"/> | 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: \_\_\_\_\_

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**For Office Use Only**

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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)

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