Child Health/Dental History Form

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ❑ F ❑	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood, 4. Exposure to Corona Virus / Covid-19?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

General Consent

Dentist: _____ Patient: _____

	INITIALS
WORK TO BE DONE I understand that I am having at least one of the following done: X-rays, Examination, Fillings, Crowns, Bridges, Onlays, Root Canals, Dentures, Periodontal treatment and/or Other:	
DRUGS AND MEDICATION I understand that antibiotics, anesthetics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications I am currently taking, which I have done.	
PARESTHESIA I understand that I may have loss of feeling in my teeth, lips, tongue, and surrounding tissue (paresthesia) following injections for local anesthesia with any procedure. Rarely, temporary, or permanent nerve injury and loss of feeling may result from an injection.	
CHANGES IN TREATMENT PLAN I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. For example, I may need root canal therapy following routine restorative procedures such as fillings, crowns, bridges, or onlays. The dentist will explain all changes.	
CROWNS, ONLAYS, BRIDGES AND CAPS A crown or onlay is typically used to strengthen a tooth damaged by decay, fracture, or previous restorations. It can also be used to serve to protect a tooth that has had root canal treatment, to improve the way the teeth fit together, or for esthetics. A bridge is used to replace missing teeth by placing crowns on teeth adjacent to the missing tooth space and extending artificial teeth across the space. Crowns, bridges and onlays are cemented in place and are not removable. The restoration of teeth with crowns or bridges requires two phases: 1) preparation of the tooth or teeth, making an impression of the teeth to send to a lab, and construction and temporary cementation of a temporary crown, and later, 2) removal of the temporary crown, adjustment and cementation of the completed crown when esthetics and function have been verified. I understand that I may be wearing temporary crowns, which may come off and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. It is also my responsibility to return for permanent cementation within 20 days from tooth preparation. Excessive delays may cause tooth movement that may necessitate a remake of the crown, bridge, or cap. I understand there will be additional charges for remakes due to my delaying permanent cementation. I understand that preparing a damaged tooth for a crown, bridge or onlay may further irritate the nerve (or pulp) in the center or the tooth, causing sensitivity to heat, cold or pressure, and that temporary sensitivity is a common after effect of such a procedure. If the sensitivity continues, a root canal may be needed, even though the tooth may not have hurt prior to the procedure being done. I understand that crown, bridges and onlays may alter the way my teeth fit together and make my jaw joint feel sore. This may require adjusting my bite by altering the biting surface of the restoration or adjacent or opposing teeth. I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be before cementation.	
FILLINGS Fillings are typically used to restore teeth damaged by decay when additional strengthening of the tooth is not required. Fillings can also be used to repair damaged or sensitive areas of teeth near the gumline even if no decay is present. I understand that care must be exercised in chewing on new fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that temporary sensitivity is a common after effect of a newly placed filling. If the sensitivity continues, I understand that a root canal and possibly a crown may be needed, even though the tooth may not have hurt prior to the filling being done.	
DENTURES AND REMOVABLE PARTIAL DENTURES Dentures and Removable Partial Dentures (Partials) are used to replace missing teeth. Dentures are held in place by the lips and tongue and sometimes by suction of the denture against the palate. Partials are held in place by clasping existing teeth. Both appliances are intended to be removed at least 8 hours per day and their success is dependent on the skill and tolerance of the person wearing them. Sore spots, altered speech, and difficulty in eating are common problems with new dentures. The ability to adapt to removable dentures varies widely. In some cases, a patient cannot or will not be able to use the device through no fault of fabrication. Immediate denture (placement of denture immediately after extractions) may be painful. Immediate denture may require considerable adjusting, and several relines. A permanent reline will be needed later. This is not included in the denture fee. I understand that it is my responsibility to return for delivery of the dentures. I understand that failure to keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delays of more than 30 days, there will be additional charges.	

	INITIALS
OPEN WIDE I understand that holding my mouth open during treatment may temporarily leave my jaw feeling stiff and sore and may make it difficult for me to open wide for several days. This can occasionally be an indication of a further problem. I must notify your office if this or other concerns arise.	
NO TREATMENT CAUTION I understand that if no treatment is performed, tooth decay or gum disease may progress causing me to lose one or more of my teeth. I may also experience symptoms which may be damaging to my overall health and which may increase in severity, and the cosmetic appearance of my teeth may deteriorate.	
EACH PERSON IS UNIQUE I understand that every reasonable effort will be made to ensure the success of my treatment. I further understand that each person and treatment situation is unique, and therefore, no guarantee or assurance has been given to me by anyone that the proposed treatment or surgery will cure or improve the condition(s) listed above.	

	INITIALS
I consent to the proposed treatment as described above.	_____
I have been informed of and accept the consequences if no treatment is administered.	_____
or	
I refuse to give my consent for the proposed treatment as described above.	_____

_____ _____

Signature of Patient Date:

FOR COMPLETION BY DENTIST

I attest that I have discussed the risks, benefits, consequences, and alternatives of the proposed treatment with the patient who has had the opportunity to ask questions, and I believe my patient understands what has been explained.

_____ _____

Signature of Doctor/Hygienist: Date:

_____

Witness:

Acknowledgement of Receipt of Notice of Privacy Practices
and
HIPAA Patient Consent

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

I, _____, have received a copy of the Notice of Privacy Practices.
Print Patient Name

_____ _____
Signature Date