CHILD'S HISTORY & INFORMATION

Child's Name _____ / _____ / _____
First Middle Last

Age_____ Sex _____ Birthdate _____ Is Child Adopted? Yes No

Address: Street_____

City_____ State _____ Zip _____

Home Phone _____ Cell Phone _____Email _____

Name and Age of Siblings _____

Child's Physician _____ Physician Phone _____

Family Dentist_____ Dentist's Phone _____

Whom may we thank for referring you to us? _____

Parent 1 Name _____ / _____ / _____
First Middle Last

Birthdate _____ SSN _____ Marital Status _____

Employer_____ Phone _____

Parent 2 Name _____ / _____ / _____
First Middle Last

Birthdate _____ SSN _____ Marital Status _____

Employer_____ Phone _____

Insurance Subscriber for this account: Parent 1 _____ Parent 2 _____ Other _____

Primary Dental Insurance_____ Group #:_____ Phone _____

Secondary Dental Insurance_____ Group #:_____ Phone _____

CHIEF COMPLAINT

PURPOSE OF VISIT

_____

_____

_____

_____

_____

Current medications/Medical treatments:

_____

_____

_____

_____

_____

_____

Remarks:

_____

_____

_____

_____

_____

PAST MEDICAL HISTORY

DOES THE CHILD HAVE OR HAS THE CHILD HAD ANY OF THE FOLLOWING-INDICATE WITH AN (X)

( ) ADD/ADHD
( ) Allergies
( ) Anemia or Blood Problems
( ) Arthritis/Joint Pain
( ) **Asthma/Breathing problems**
( ) Bleeding problems
( ) Bone or Muscular problems
( ) Bronchitis
( ) Cancer/Other tumors
( ) Cerebral Palsy
( ) Diabetes
( ) Disabilities (mental, physical, emotional)
( ) Ear/Hearing difficulties
( ) Endocrine/Glandular problems
( ) Eye/Vision problems
( ) **Heart Defects**
Is premedication needed Y or N
( ) Hepatitis/Jaundice
( ) HIV Infection/AIDS
( ) Hospitalization-date_____
( ) Kidney/Urinary tract problems
( ) Learning disorders
( ) Nervous/Seizure problems
( ) Rheumatic fever
( ) Radiation treatments
( ) Stomach/Digestion problems
( ) Surgery-date_____
Height _____
Weight _____

PAST DENTAL HISTORY

HAS THE CHILD HAD ANY PREVIOUS DENTAL EXPERIENCES WHICH WERE UNFAVORABLE?
(YES) (NO)

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING-INDICATE WITH AN (X)

( ) Bad Breath
( ) Bedtime nursing bottle
( ) Bleeding Gums
( ) Brushing frequency _____
( ) Clinching or grinding of teeth
( ) Complications from extractions
( ) Dental flossing frequency _____
( ) Fluoride supplements
( ) Food impaction
( ) Frequent blisters on lips or mouth
( ) Mouth breathing
( ) Mouth Ulcers
( ) Oral habits (thumbsucking, nail biting, pacifier, cheek biting, tongue thrust)
( ) Orthodontic treatment
( ) Pain around ears
( ) Sensitivity to cold, hot, sweet, pressure
( ) Swelling or lumps in mouth
( ) Toothbrush texture _____
( ) Traumatic injury to mouth or teeth

PLEASE READ AND SIGN REVERSE SIDE

OFFICE POLICY AND TREATMENT CONSENT

APPOINTMENTS: Each appointment represents a specific amount of time reserved for your child's dental care. If some problem arises so that you are unable to keep this time, we request a proper notification of cancellation (24 hours). **A broken appointment fee will be charged for all missed appointments.** _____ **Initial Here**

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are responsible for payment of fees. We will be happy to complete and assist in filing your insurance claim, upon receipt of full (or partial) payment. We do not render our services on the basis that insurance companies will pay all our fees. **You are responsible for knowing your own insurance coverage.** _____ **Initial Here**

CONSENT: I hereby certify that the foregoing information is correct. Because the child is a minor, it becomes necessary that signed permission be obtained from the parent (guardian) before any necessary dental treatment can be started. If the use of premedication and/or anesthesia is indicated, I consent to the administration of such premedication and/or anesthesia as the doctor may deem advisable and proper. Furthermore, I will be responsible for any financial obligations incurred on this child for dental treatment. **In the event that my account requires collections and/or attorney services, I understand that I will be held responsible for all fees.** _____ **Initial Here**
We will inform you of all services and their charges before any of the services are rendered for your child.

_____

Signature of Parent/Guardian Date

I have read over my child's history and information. To the best of my knowledge, there are currently NO changes.

X _____ Date	X _____ Date	X _____ Date
X _____ Date	X _____ Date	X _____ Date
X _____ Date	X _____ Date	X _____ Date
X _____ Date	X _____ Date	X _____ Date
X _____ Date	X _____ Date	X _____ Date

Associated Pediatric Dentistry

Belleville, Edwardsville, O'Fallon, Mt. Vernon, IL

Patient Name:_____ DOB:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT

****You May Refuse to Sign This Consent Acknowledgement****

I, _____, have been informed of this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice. I fully understand that I can refuse to sign this consent acknowledgement or I may revoke my consent at any time in writing.

Please note that refusal to sign would affect our ability to submit insurance claims on your behalf. This action would require payment in full at the time of service.

_____
{Please 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)

Staff Signature_____ Date_____