GENERAL INFORMATION – CHILD/TEENAGER

Please fill in completely.

A. Child's Name__________________________________ Nickname__________________ Age______ Birthday_____________

B. Home Address__________________________________ City ______________________________ Phone________________

C. School______________________________ Grade____________ Favorite hobby or past time__________________________

D. Father's Name____ Employed by ___________________________

Occupation _______________________ How Long_____________ Business Address________________________________

E. Mother's Name____ Employed by_____________________________

Occupation________________________ How Long______________ Business Address________________________________

F. Person Responsible for Account__________________________ Soc. Security No.___________________ DOB: ___________

G. Whom may we thank for referring you to our office? ____

If from an advertisement where did you see the ad? ____

H. If you have no phone, please list a number where you may be reached to verify appointments, et cetera: __________________

Phone Number ____

I. Children in family_______ (Names and ages) ____

a. Do you know that fluoride can help to prevent decay in children's teeth? _______

b. Are your children taking fluoride drops or tablets each day? __________________

c. Have they been given topical treatments of fluoride? ________________________

J. Name of your physician (MD) ____ City ______________________________

When last seen ______________________ for what reason ____

K. Former Dentist ____ City ______________________________

When last seen ______________________ for what reason ____

REASON FOR THIS VISIT:

Examination, X-rays (and study models, if necessary) _____________ Emergency treatment ______________________________

PAYMENT OF PROFESSIONAL FEES:

(Routine dental services, emergency care, must be paid for at time of treatment.)

A. Cash
B. Check
C. Credit Card (MasterCard, Visa, Discover, and CareCredit accepted)

CONSENT:

I hereby authorize that all necessary dental services and methods be rendered for:

Child's Name:____Date:______________________

Signature of person filling out this form:____ Relationship:___________________

WHAT IS BEST DAY AND TIME FOR DENTAL APPOINTMENTS? ____

(The answers to these questions are for our records only, and will be considered confidential. Thank you for your cooperation.)

CHILD/TEENAGER PATIENT MEDICAL AND DENTAL HEALTH QUESTIONNAIRE

(The answers to the following questions are for our records only, and will be considered confidential. Thank you for your cooperation.)

*Name:*____

1. Is your child under the care of a physician now? __________ **YES NO**

   If yes, for what?__________

2. Is your child taking any medication at this time? __________ **YES NO**

   If yes, what, and what is it for:__________

3. Is your child allergic to anything: penicillin, antibiotics, other drugs, metals or latex? __________ **YES NO**

   If yes, please specify:__________

4. Does your child have regular check-ups by a physician? __________ **YES NO**

5. Does your child have regular check-ups by a dentist? __________ **YES NO**

   If no, is this their first visit?__________

6. Has your child ever had a severe blow to face or teeth? __________ **YES NO**

   If yes, when and how?:__________

7. Does your child have a toothache now? __________ **YES NO**

8. Has your child ever had local anesthesia ("novocaine")? __________ **YES NO**

9. Has your child ever had a tooth extracted? __________ **YES NO**

   If yes, were there complications?__________

10. Has your child had psychiatric care or treatment? __________ **YES NO**

11. Has your child had any unfavorable reaction to previous medical or dental care? __________ **YES NO**

    If yes, please specify:__________

12. Does your child have any fears of dentistry? If yes please specify: __________ **YES NO**

13. Can your child take pills easily? __________ **YES NO**

14. Does child have frequent difficulty in breathing through his nose? __________ **YES NO**

    Frequent or severe nosebleeds? __________

    Frequent cold sores or canker sores? __________

15. Are your child's teeth brushed regularly? _________ If yes, by whom? __________ **YES NO**

    ☐ Upon rising ☐ After eating any food ☐ Right after meals ☐ Before going to bed

16. Does your child have any habits which might affect the teeth or mouth? Please check:

    ☐ Breathes through mouth ☐ Tongue habits ☐ Bites/ sucks lip ☐ Bites fingernails ☐ Sucks thumb/ fingers

17. Has your child ever had orthodontic care? If yes when? __________ **YES NO**

    If no, was it ever suggested by a dentist? __________

18. Does your child take a vitamin supplement daily? _________ What brand? __________ **YES NO**

19. Has your child had fluoride treatments? If yes please check: __________ **YES NO**

    ☐ Community water ☐ Well water ☐ Fluoride rinse or gel ☐ Fluoride drops or tablets

20. Has your child ever been hospitalized? If yes, when and what for? __________ **YES NO**

21. Please check if your child has had any of the following illnesses:

☐ Measles	☐ Liver Disease	☐ Asthma	☐ Sinusitis	☐ Heart Disease
☐ Mumps	☐ Kidney Disease	☐ Whooping Cough	☐ Headaches	☐ Bronchitis
☐ Chicken Pox	☐ Ear/Eye Trouble	☐ Diabetes	☐ Frequent Colds	☐ HIV/Aids
☐ Scarlet Fever	☐ Tuberculosis	☐ Epilepsy	☐ Faint Spells	☐ Heart Murmur
☐ Rheumatic Fever	☐ Anemia	☐ Polio	☐ Jaundice	☐ Other

I certify that the above information is correct to the best of my knowledge.

Date:_____________________ Parent's/Guardian's Signature:__________________________________

Appointment Reminders

We will contact you in advance to confirm your appointments. Please check which method you would prefer to be notified:

☐ Phone ____

☐ E-mail ____

☐ Text_________________________________ Cell Phone Carrier_____________________

Appointment Cancellation Policy

When we schedule an appointment for you, we are setting aside a dedicated chair and time slot just for you. If you must reschedule your appointment, please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who may be waiting to get in.

There will be a charge of $50 for failing a scheduled appointment. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt.

I have read and understand the Appointment Cancellation Policy:

Patient Name____

Patient Signature____ Date___________________

HIPPA PRIVACY NOTICE

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:____

Signature:____

Relationship to Patient:____

Date:_____________________________

I give permission for ________________________________ to have access to my dental records.

Spring Valley Dentistry
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