Child Health History Form

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name Relationship to Patient	Parent's/Guardian's Email Sign up for Specials/Monthly News Letter Yes ☐ No ☐	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home ( ) Work ( ) Cell ( ))		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?
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? ..... 1. If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____ 2.	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____ 3.	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____ 5.	❑	❑
6.	Has the child ever been hospitalized? ..... 6.	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____ 7.	❑	❑
8.	Has the child ever received a general anesthetic? ..... 8.	❑	❑
9.	Does the child have any inherited problems? ..... 9.	❑	❑
10.	Does the child have any speech difficulties? ..... 10.	❑	❑
11.	Has the child ever had a blood transfusion? ..... 11.	❑	❑
12.	Is the child physically, mentally, or emotionally impaired? ..... 12.	❑	❑
13.	Does the child experience excessive bleeding when cut? ..... 13.	❑	❑
14.	Is the child currently being treated for any illnesses? ..... 14.	❑	❑
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: _____ 15.	❑	❑
16.	Has the child had any problem with dental treatment in the past? ..... 16.	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed? ..... 17.	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth? ..... 18.	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth? ..... 19.	❑	❑
20.	Has the child had any orthodontic treatment? ..... 20.	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?** ..... 22.	❑	❑
23.	**Is fluoride toothpaste used?** ..... 23.	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____ 24.	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier? ..... 25.	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities? ..... 27.	❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all 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 _____

2220 Coit Rd. Ste. 570
Plano, TX 75075
Ph: 972-964-6500
Fx: 972-964-6511

Patient:_____ DOB:_____ BP:_____

Dentist:_____ Pulse:_____

1. WORK TO BE DONE: I understand that I am having the following work done (indicate all services being provided): ( ) Fillings, ( ) Bridges, ( ) Crowns, ( ) X-rays, ( ) Extractions, ( ) Impacted Teeth Removal, ( ) Root Canals, ( ) Dentures, ( ) Other _____

Patient Initials _____

2. DRUGS AND MEDICATION: I understand tat antibiotics, analgesics and other medications may cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting, and/or anaphylactic shock. I have advised my dentist of any and all medications I am currently taking., including but not limited to prescriptions medications, over-the-counter medications, herbal remedies, and alternative medications. I further understand that failure to advise my dentist of any medications I am taking prior to starting dental work may have unforeseen negative consequences for me.

Patient Initials _____

3. 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 discoverable during previous examinations. For example, root canal therapy may be necessary following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary.

Patient Initials _____

4. REMOVAL OF TEETH: Alternatives to removal has been explained to me (root canal therapy, crowns, periodontal surgery, etc), and authorize the dentist to remove the following teeth: _____, and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved with extractions, some of which are pain, swelling, spread of infection, dry socket, and loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time, and fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost of which is my responsibility.

Patient Initials _____

5. CROWNS, BRIDGES AND CAPS: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crowns, bridge, or cap (including shape, fit and color) will occur only before final cementation. It is also my responsibility to return for permanent cementation within 21 days from initial tooth preparation. Excessive delays may allow for tooth movement which may necessitate a remake of the crown, bridge or cap. In such instances, I understand that there will be additional charges for remakes due to my delaying permanent cementaion.

Patient Initials _____

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6. ENDODONTIC TREATMENT (ROOT CANAL): I realize there is no guarantee that toot canal therapy will save my tooth, and that complications can occur from the treatment, and that occasionally root canal filling material may-extend through the tooth which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacture can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy). I understand that the tooth may be lost in spite of all efforts to save it.

Patient Initials _____

7. PERIODONTAL LOSS (TISSUE AND BONE): I understand that if I am being treated for periodontal disease, this means I have a serious condition, causing gum and bone inflammation or loss and that it can ultimately lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and/or extractions. I understand that any dental procedure may have future adverse effect on my periodontal condition.

Patient Initials _____

8. Fillings: I understand that care must be taken when chewing on fillings specially 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 increased sensitivity is a common effect of a newly placed filling.

Patient Initials _____

9. DENTURES: I understand the wearing of dentures is difficult. Sore spots, altered speech, and difficulty in in eating are common problems associated with dentures. Immediate dentures (placement of denture immediately after extractions) may be painful. In addition, immediate dentures often 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 keep my delivery appointment may result in poorly fitted dentures. If a remake is required due to my delay of 30 days or more, there may be additional charges assessed against me.

Patient Initials _____

I understand that dentistry is an inexact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment(s) which I have requested and authorized. I hereby authorized any of the doctors or dental assistants or auxiliaries to proceed with and perform the dental restorations and treatments indicated above and as explained to me. I understander that this is only an estimate and subject to modification depending on unforeseen or undiagnosed circumstances that my arise during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I may be responsible for payment of the dental fees.

Signature of Patient: _____ Date: _____

Signature of Patient Guardian: _____ Date: _____

FINANCIAL AGREEMENT

For the purposes of this document, the "dental practice" is _____

Our goal is that our patients understand their treatment needs, as well as its exclusive financial responsibility before starting treatment. It is our desire to make affordable dental care to all our patients. Please review the following policies and procedures:

PAYMENT POLICY: Payment is due at the time of the service. If you have dental insurance, your estimated co-payment plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit.

1. We accept cash, personal checks with proper identification, money orders, debit cards, Visa, MasterCard, Discover, American Express
2. If there is a balance and charges have been in the account for more than 90 days, you will have to pay the Dental Practice 18% finance charge per month on the outstanding balance until it is paid in full.
3. You will be responsible for any and all expenses incurred in the collection of the debt (i.e., collection costs, court fees and/or attorney fees)
4. Financing is available through Care Credit and Compassionate Care with prior approval.
5. A fee of $ 35 if applicable for any check returned by the bank.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

1. You must provide us with an insurance card and/or all information necessary to verify your coverage and file your claim.
2. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you; not with your insurance company.
3. You are responsible for paying our fees; not what your insurance company allows or considers "usual, customary and reasonable" (UCR), all of which vary from one company to another.
4. Although we can estimate your insurance benefits we are not responsible for their accuracy. Knowing the amount of your benefits, limitations, exclusions, waiting periods, etc. is entirely your own responsibility. Receiving our services implies the acceptance of responsibility to pay regardless of our estimate.
5. All charges not paid by your insurance company are your responsibility, regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits vary from one company to another. Rates for non-covered services, plus deductibles and co-payments are due at the time of treatment.
6. Treatment provided in another dental office during the current plan year may alter your co-payments due for services in our office. In such cases we are not able to track whether or not you have reached your yearly maximum. Please call your insurance company if this applies to you.
7. There are many factors in determining patient responsibility in case of coordination of benefits between two insurance companies. We will provide you the most accurate information available to us, but we cannot guarantee what your out of pocket benefit will be.
8. Please understand that our responsibility is to provide treatment that best suits your needs, not to try to match your care to insurance plan limitations.

CANCELLED OR MISSED APPOINTMENTS: To cancel an appointment, you must notify us at least 24 hours in advance to avoid a missed appointment fee of up to $ 50.00 (fee based on consultation length and/or the number of missed appointments). Missed or cancelled appointments prevent others from receiving the dental care they deserve.

1. We reserve the right to terminate or suspend professional treatment of any patient when scheduled appointments are not kept.

I have read and understood this document in its entirety; outlining the office and financial policies of the dental practice and agree to these terms.

Patient Name / guardian _____

Signature of Patient / guardian_____ Date: _____

HIPAA CONSENT FORM

The Health Insurance Portability and Accountability Act of 1996 provide safeguards to protect your privacy. These Safeguards include restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you or your family with treatment. HIPAA provides certain rights and protections to you as the patient. We must balance these needs with our goal to providing you with quality service and care. For this reason, our practice has adopted the following polices:

1. Patient information will be kept confidential except as is necessary to provide treatment or to ensure that all administrative matters related to your care are handled appropriately. Patient files may be stored in open file racks but will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left in administrative areas such as the front office, Doctor's office, etc. The patient agrees to the normal procedures utilized within the facility for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of the office to remind patients of their appointments. This may be done by telephoning patients or by any other means convenient for the practice.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but agree to abide by the rules of confidentiality.

4. The patient understands and agrees to inspections of the office and review of documents which may include PHI by government agencies or insurance companies through the normal performance of their duties.

5. The patient agrees to bring any concerns or complaints regarding privacy to the attention of the Doctor or office manager.

6. Your confidential information will not be used for purposes of advertising or marketing of products, goods, or services. Such prohibition does not include treatment/product samples or goods of normal value.

7. The practice agrees to provide the patient with access to their records in accordance with state law.

8. The practice may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

I, _____, do hereby agree to the terms set forth above and any subsequent changes in the office policy. I understand that this consent shall remain in force so long as I am a patient of this practice.

_____ _____

Patient or Guardian Signature: Date: