

Child Health/Dental History Form

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth
Parent's/Guardian's Name			Relationship to Patient	
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>				
Phone <small>Home Work</small>			Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/>	

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:

- | | | | | | |
|---|--|--|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV +/-AIDS | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Fainting | <input type="checkbox"/> Immunizations | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tobacco/Drug Use |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Kidney | <input type="checkbox"/> Pregnancy (teens) | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Hearing | <input type="checkbox"/> Latex allergy | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Bleeding disorders | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart | <input type="checkbox"/> Liver | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bones/Joints | <input type="checkbox"/> Ear Aches | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Measles | <input type="checkbox"/> 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: _____ | 1. <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____ | 2. <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____ | 3. <input type="checkbox"/> | <input type="checkbox"/> |
| 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. <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Has the child ever been hospitalized? | 6. <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does the child have a history of any other illnesses? If yes, please list: _____ | 7. <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has the child ever received a general anesthetic? | 8. <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does the child have any inherited problems? | 9. <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does the child have any speech difficulties? | 10. <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Has the child ever had a blood transfusion? | 11. <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Is the child physically, mentally, or emotionally impaired? | 12. <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Does the child experience excessive bleeding when cut? | 13. <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Is the child currently being treated for any illnesses? | 14. <input type="checkbox"/> | <input type="checkbox"/> |
| 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. <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Has the child had any problem with dental treatment in the past? | 16. <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Has the child ever had dental radiographs (x-rays) exposed? | 17. <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Has the child ever suffered any injuries to the mouth, head or teeth? | 18. <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Has the child had any problems with the eruption or shedding of teeth? | 19. <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Has the child had any orthodontic treatment? | 20. <input type="checkbox"/> | <input type="checkbox"/> |
| 21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water | | |
| 22. Does the child take fluoride supplements? | 22. <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Is fluoride toothpaste used? | 23. <input type="checkbox"/> | <input type="checkbox"/> |
| 24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____ | 24. <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Does the child suck his/her thumb, fingers or pacifier? | 25. <input type="checkbox"/> | <input type="checkbox"/> |
| 26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____ | | |
| 27. Does child participate in active recreational activities? | 27. <input type="checkbox"/> | <input type="checkbox"/> |

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 _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (04/10/2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain