ADA American Dental Association®
America's leading advocate for oral health

Today's Date: _____

# Child's Dental & Medical Health History Information

**To the parents/guardians of the patient:** Please know that we may ask follow-up questions to make sure we have all of the information we need in order to treat the patient.

## PATIENT INFORMATION

Last Name: First Name: Middle Name: Nickname:

Date of Birth: / / Gender:

Parent's/Guardian's Name: Relationship to Patient:

Email Address:

Home Phone: Cell Phone: Work Phone:

Mailing Address: City: State: Zip:

**Please use an "X" to mark your answers to the following question.**

Have you (the adult) or the patient (the child) had? ☐ A cough that's lasted longer than three weeks ☐ A cough that produces blood ☐ Active Tuberculosis

**Please bring this form to the receptionist right away if you marked "Yes" to any of these items.**

## PATIENT'S DENTAL HEALTH HISTORY

What is the reason for your visit today?

How would you describe the patient's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Does the patient currently have any dental pain or discomfort? ☐ Yes ☐ No If yes, where? _____

Is this the patient's first visit to a dentist? ☐ Yes ☐ No
If no, when was the patient's last dental exam? _____ What was done at that appointment? _____

When was the last time the patient had dental x-rays taken?

| **Please use an "X" to mark your answers to the following questions.** | **Yes** | **No** | **?** |
|---|---|---|---|
| Has the patient had any problem with dental treatment in the past? If yes, please describe what happened: _____ | ☐ | ☐ | ☐ |
| Has the patient had any problems with teeth coming in or losing teeth? | ☐ | ☐ | ☐ |
| Does the patient use fluoride toothpaste when brushing teeth? How often are the patient's teeth brushed? _____ time(s) per _____ At what time(s) of day are the teeth brushed? _____ | ☐ | ☐ | ☐ |
| Has the patient ever worn braces or other orthodontic appliances? | ☐ | ☐ | ☐ |
| Has the patient ever had a serious injury to the head, mouth or teeth? If yes, please describe what happened and when it happened: _____ | ☐ | ☐ | ☐ |
| Does the patient play any contact sports or participate in active recreational activities? If yes, please describe those activities here: _____ | ☐ | ☐ | ☐ |
| Is your home water supply fluoridated? | ☐ | ☐ | ☐ |
| What is the patient's primary source of drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Well | | | |
| Does the patient take fluoride supplements? | ☐ | ☐ | ☐ |
| Does/did the patient use a pacifier or suck his/her thumb or fingers? At what age did the patient stop breastfeeding? _____ At what age did the patient stop bottle feeding? _____ | ☐ | ☐ | ☐ |
| Has the patient ever experienced any sleep-related breathing disorders? ☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep | | | |

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## PATIENT'S MEDICAL HEALTH HISTORY & VACCINATION STATUS

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

Doctor's Name: _____ Phone: _____

Does the patient see any medical specialists? ☐ Yes ☐ No If yes, please explain. _____

| **Please use an "X" to mark your answers to the following questions.** | **Yes** | **No** | **?** | |
|---|---|---|---|---|
| Is the patient currently being treated for any condition(s) or illness(es)? | ☐ | ☐ | ☐ | If yes, what is the illness and when did it start? |
| Has the patient ever had a serious illness? | ☐ | ☐ | ☐ | If yes, what was the illness and when did it happen? |
| Has the patient ever been hospitalized? | ☐ | ☐ | ☐ | When and why? |
| Has the patient ever been given a general anesthetic? | ☐ | ☐ | ☐ | |
| Has the patient ever had a blood transfusion? | ☐ | ☐ | ☐ | |
| Does the patient experience excessive bleeding when cut? | ☐ | ☐ | ☐ | |
| Has a physician or dentist ever suggested that the patient take antibiotics before seeing the dentist? | ☐ | ☐ | ☐ | If so, please explain why and provide the name of the doctor making that recommendation. Doctor's Name: _____ Phone: _____ |
| Has the patient been diagnosed with any physical, developmental, mental or emotional conditions? | ☐ | ☐ | ☐ | If yes, please explain. |
| Does the patient have any genetic (inherited) conditions? | ☐ | ☐ | ☐ | If yes, please explain. |
| Does the patient have any speech difficulties? | ☐ | ☐ | ☐ | If yes, please explain. |

How would you describe the patient's eating habits?

Is the patient up-to-date with immunizations related to childhood diseases (tetanus, measles, mumps, etc.)? ☐ Yes ☐ No

If of the appropriate age, what is the patient's Human papillomavirus/HPV immunization status? ☐ Immunized ☐ Not immunized

**Please check the box in front of any health conditions or issues the patient has now or has had in the past:**

- ☐ ADD/ADHD
- ☐ Alcohol/Drugs
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder problems
- ☐ Bleeding disorders
- ☐ Bone/Joint issues
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Chronic sinusitis
- ☐ Diabetes
- ☐ Ear aches
- ☐ Epilepsy
- ☐ Fainting
- ☐ Growth problems
- ☐ Hearing problems
- ☐ Heart Issue
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Immunizations
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Pregnancy (teens)
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually transmitted infection (STI)
- ☐ Sickle Cell Anemia
- ☐ Thyroid issues
- ☐ Tobacco/Vaping
- ☐ Tuberculosis
- ☐ Other: _____

## MEDICATIONS & ALLERGIES

| **Please use an "X" to mark your answers to the following questions.** | **Yes** | **No** | **?** |
|---|---|---|---|
| Is the patient currently taking any prescription medications, vitamins, supplements and/or over-the-counter medications? If yes, please list them here: _____ | ☐ | ☐ | ☐ |
| Is the patient allergic to any antibiotics (penicillin), pain medications (acetaminophen, ibuprofen, opioids) or any other medications? If yes, please list those medications and what happened when the patient took them: _____ | ☐ | ☐ | ☐ |
| Does the patient have other allergies, such as to latex, metals, certain foods, animals, plants, etc.? If yes, please describe the allergy and the reaction: _____ | ☐ | ☐ | ☐ |

**NOTE: I understand that it's important for both the dentist and the patient or his/her parent/guardian to talk honestly about the patient's health before dental treatment starts. I have answered all of the questions above completely and accurately. I understand that the dentist and his/her staff need this information so the patient receives the right kind of dental care. I represent and warrant that I have full legal right and authority to consent to the performance of any procedure(s) on this patient. If for any reason I no longer have such legal right and authority, I will immediately notify the practice in writing.**

The dentist and I have talked about any questions I had about this form.

I will not hold the dentist, or any other member of his/her staff, responsible for anything they did, or didn't do, because of any mistakes I might have made in filling out this form.

Signature of Parent/Legal Guardian: _____ Date: _____

## FOR COMPLETION BY DENTIST

Comments: _____

**Office Use Only:**

☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia

Reviewed by: _____ Date: _____

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**Dental Associates of Rockville, LLC**
**50 Hale Street**
**Rockville, CT 06066**

## OFFICE AND FINANCIAL POLICY
## AUTHORIZATION TO PAY BENEFITS AND TO RELEASE INFORMATION

Payment for services is due at the time services are rendered. We accept cash, checks, credit cards, and CareCredit. Returned checks and account balances older than 90 days may be subject to additional fees.

**Attendance Policy: We must have 48 hours (2 days) notice of cancellation of appointments. If we do not have the required 48-hour cancellation notice, you may be charged a "No Show" fee of $50-150 (depending on service type). Patients that miss two or more appointments without calling to cancel/change their appointment will be discharged/dismissed from our practice. We currently have a waiting list of patients for appointments. If you cannot make your appointment, please notify us so we can give someone else that appointment time. Frequent missed appointments have a huge impact on our ability to see and treat our patients and cannot be overlooked.**

**Denture/Laboratory Cancellation Policy:** Once impressions have been taken and a denture or partial denture case has been submitted to the dental laboratory, the patient is responsible for all laboratory fees and professional services incurred up to the date of cancellation. These fees are nonrefundable because the laboratory begins custom fabrication specifically for the patient.

As a courtesy, our office may contact you via phone, text message, or email regarding appointments, treatment, and financial matters. REMINDER, your estimated patient portion is due at the time of service. A BILLING FEE is applied to balances over 60 days.

Please understand that your dental insurance is a contract between you, your employer, and your insurance company. Our office is not a party to that contract, and coverage varies by plan. Not all services are covered benefits.

As your dental care provider, our financial relationship is with you, not your insurance company. While we are happy to file insurance claims as a courtesy, you are ultimately responsible for all charges from the date services are rendered, including any amount not paid by your insurance.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

I understand and agree that, regardless of my insurance coverage, I am ultimately responsible for payment of all charges for professional services rendered to me, including any balance not paid by my insurance.

I authorize payment of applicable insurance benefits directly to the above-named dentist and authorize the dentist/practice to submit claims and release information necessary to my insurance company, claim administrator, or other healthcare professionals for the purpose of processing and administering my benefits.

_____ _____

Patient's signature Date

# Dental Associates of Rockville, L.L.C.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This form complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone #: _____ Social Security# _____

## Consent for Use and Disclosure of Health Information

**Authorization:** I authorize Dental Associates of Rockville, L.L.C. to use or disclose the following: (check one)

☐ - All of my health information.

☐ - My health information ONLY related to: _____

☐ - My health information from (dates) _____ to _____

☐ - Not Applicable

**Disclosure:** Dental Associates of Rockville, L.L.C. can disclose my health records per the above selected conditions to:

Name: _____

Relationship to Patient: _____

Address: _____

Phone: _____ Email: _____

### Please read the following statements carefully

**Purpose of Consent:** By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations. You consent to our disclosure of your protected health information all or in part to the party listed above. You also authorize insurance payment directly to this office.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. A copy is available for you and we encourage you to read it carefully.

**Right to Revoke:** You have the right to revoke this consent at any time by giving us written notice of your revocation submitted to our contact person. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

### Signature:

I, _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations; and to the party I listed in the disclosure section of this document.

**Signature:** _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

**Personal Representative's Name:** _____ **Date:** _____

**Relationship to Patient:** _____