Pediatric Dentistry Health History

Child's Full Name: _____ Nickname:_____ Sex: M F

Date of Birth: ___/___/____ Age: _____ SSN # _____ Best Phone # (___) _____

Address: _____
Street City State Zip

Grade: _____ School: _____

Name(s) and ages of other children in family: _____

Name(s) of your other children seen in this office: _____

Please list the child's hobbies/ interests: _____

How did you hear about our office? _____

Who is accompanying the child today? _____ Relation: _____

Who has legal custody of this child? _____

Insurance Company: _____ I.D. _____

Parent/Legal Guardian Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

☐ **Mother** ☐ **Step Mother** ☐ **Guardian**

Name: _____ Driver's License #: _____ State_____

Date of Birth: _____/_____/_____ SSN # _____

Address: _____
Street City State Zip

Home/Cell Phone #: (____) _____ Work Phone #: _____

Email: _____

Employer: _____

Dental Insurance: Yes ___ No___ Company _____

☐ **Father** ☐ **Step Father** ☐ **Guardian**

Name: _____ Driver's License #: _____ State_____

Date of Birth: _____/_____/_____ SSN # _____

Address: _____
Street City State Zip

Home/Cell Phone #: (____) _____ Work Phone #: _____

Employer: _____

Dental Insurance: Yes ___ No___ Company _____

Emergency Contact

His/Her Name: _____ Relation: _____
Work Phone #: (____) _____ Home Phone #: (____) _____
Cell/Mobil/Pager/Other Phone # (___) _____ (___) _____

Medical History

Child's Physician: _____

Phone #: (____)_____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain :_____

_____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Are immunizations current? ☐ Yes ☐ No

Please list all medications that the child is currently taking: _____

Please list all medications/foods/other that cause the child allergic reactions: _____

_____

Has the child been diagnosed with or treated for any of the following:

Y N Abnormal Bleeding	**Y N** Cleft Palate/ Lip	**Y N** Hepatitis Type ___
Y N AIDS/HIV+	**Y N** Diabetes	**Y N** High/Low Blood Pressure
Y N Anemia	**Y N** Epilepsy/Seizures	**Y N** Hives
Y N Hospital Stays/Surgery	**Y N** Handicaps/Disabilities	**Y N** Kidney Problems
Y N Asthma	**Y N** Hearing/ Speech	**Y N** Liver Problems
Y N Blood Transfusion	**Y N** Heart Disease	**Y N** Rheumatic Fever
Y N Cancer	**Y N** Heart Murmur	**Y N** Sickle Cell Anemia
Y N Cerebral Palsy	**Y N** Hemophilia Type ___	**Y N** Tuberculosis (TB)

Please describe the above and any other medical problems the child has/had: _____

_____

Does anyone in the family have a history of Malignant Hypothermia? ☐ Yes ☐ No

When was the child's last E.R. visit and why? _____

_____

Dental History

What is the Primary reason for today's visit? _____

Is your child currently having problems with any of the following?

☐ Cavities ☐ Toothache ☐ Sensitive Teeth ☐ Trauma

☐ Gum Infection ☐ Color of Teeth ☐ Tooth Alignment ☐ Other _____

Has the child experienced problems with previous dental work? ☐ Yes ☐ No Explain: _____

Is the child's home water supply fluoridated? ☐ Yes ☐ No

Does the child brush his/her teeth daily with fluoride toothpaste? ☐ Yes ☐ No

Do you give the child any other form of fluoride? ☐ Yes ☐ No

Does the child floss his/her teeth daily? ☐ Yes ☐ No

Does your child suck a finger/thumb/pacifier/ or exhibit any other habits? _____

Previous Dentist: _____ Date of last visit? _____

Why did you leave your last dentist? _____

What did you like most about any dentist you have seen? _____

Least? _____

Kids First Sedation and General Anesthesia Policy

All forms of sedation, nitrous, and general anesthesia are typically not covered by insurance. Payment for these procedures will be expected before booking. We will be glad to bill any insurance for all needed sedation options on your behalf, and will reimburse you if any payment is received.

Signature _____ Date_____

Relationship to child _____

Authorizations and Consent

APPOINTMENTS – In order to provide each child with the individual care and attention that they deserve, we ask that you arrive on time for scheduled appointments. We work very hard to see each patient at their scheduled appointment time. Due to the nature of our practice, however, when dealing with children, accidents and emergencies do happen. We ask for your patience if we are delayed in seeing your child due to treating another child on an emergency basis.

We require twenty four (24) hour notice if you must change a scheduled dental appointment. Less than 24 hour notice, or not showing for an appointment, is considered a missed appointment. Missing a scheduled appointment is counterproductive for both the patient and our office.

CONTACT- I agree to receiving text, emails, phone calls, mail and other forms of correspondence in regards to appointments, treatment and any other reasons by our office.

PAYMENT – Payment can be made by cash, check, and credit card. If paying by cash, please bring small bills. We usually do not have change for large bills. Fees for any treatment diagnosed will be discussed with you at your initial appointment. Payment arrangements/finance options are available through our office.

INSURANCE – Please provide the front office staff with your insurance card so that we can contact your insurance company regarding your benefits. We will file your insurance claims and work with your insurance company concerning their portion of treatment fees on your behalf. Remember, even if you have insurance coverage, you are responsible for payment of your account. Your insurance coverage is a relationship between you, the insured patient, and your insurance company. We have no influence over your coverage.

PHOTO RELEASE – I, the undersigned, do hereby relinquish any and all rights to photographs, portraits, transparencies, negatives, prints, Polaroid or other photographic reproductions captured with still, motion picture, video, digital or other cameras for use by this office.

CONSENT FOR DENTAL TREATMENT – I request and authorize Dr. Grewal and his staff to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Grewal to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or my child's teeth for diagnostic and educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Grewal and his staff will provide an environment designed to help children learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments, and using variable voice tone.

I have reviewed the information on the Health History Form and it is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I agree to inform the office of any changes in address, phone, employment, etc… that occur during the course of treatment for my child. If the patient is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I understand that I will be responsible for any charges incurred for dental treatment.

Patient Name: _____

Signature: _____Date: _____

Relationship to Patient: _____ Legal Guardian (if different): _____

Kids First Pediatric Dentistry

Cancellation and Broken Appointment Policy

We understand that illness, emergencies, auto issues, and bad weather do occur. We ask our patients to give us 24 hours' notice whenever possible if they cannot keep an appointment. This allows us to offer appointments to patients that are in pain or on a wait list.

Policy:

What is a Broken Appointment?

Cancellation or rescheduling of an appointment with less than a 24 hour's notice will be considered a broken appointment and chargeable.

If you do not show up for an appointment, this is a chargeable broken appointment.

If you have 3 or more NO SHOW, NO CALL appointments, you will be scheduled to speak with our management team so we can work together to ensure you are able to make all future scheduled appointments.

Fees:

Broken appointment with the Hygienist – $25.00 per every half hour scheduled

Broken Appointment with the Dentist -$50.00 per every half hour scheduled

Our number one concern is our patient's dental health. Providing services in a timely manner is critical in accomplishing that goal. Another goal is to keep the cost of dental treatment as economical as possible. The appointment you schedule for treatment is reserved for YOU! When you fail your appointment without providing us with adequate notice, this adds to the overall cost of care.

If we are unable to reach you to verbally confirm your appointment by noon the day before you are scheduled, we will have to assume that you will not be able to make it and your appointment will be taken out of our schedule.

We understand emergencies come up and therefore charges for broken appointments will be at the discretion of the Management Team. We appreciate your understanding and consideration regarding our Broken Appointment Policy. If you have any questions or concerns do not hesitate to contact us at 313-386-0570.

I have read, understand and agree to the above policy.

_____ _____

Patient Signature **Date**