



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a healthy smile with star power.

Please fill out form completely.

Date: _____

Child's Name: _____ M/ F Nickname: _____

Date of Birth: _____ Brothers/Sisters (Ages): _____

What are your child's hobbies? _____

Child's Address: _____

Phone: (Cell) _____ (Work) _____ (Home) _____

Your Name: _____ Relationship to Child: _____

Your Address (If Different): _____

Email: _____ What is the best way to contact you? _____

Husband's / Wife's Name: _____

Are you: Married Single Separated Widowed Divorced

Who is Responsible for this account? _____

Address of this person: _____

Employed By: _____ Type of work: _____

Business phone of the responsible party: _____ Alternant Business Phone: _____

How did you hear about us? _____

Whom may we thank for referring you? _____

Where/whom may we call regarding you appointment? _____

Child's Physician: _____ Phone: _____



Medical History

Please answer applicable questions by circling and elaborate below if "Yes"

Does your child have any health problems? _____ Yes / No

Has your child seen a physician in the last year? _____ Yes / No

Has your child ever been hospitalized? _____ Yes / No

Does your child take medicines regularly? _____ Yes / No

Is your child taking vitamins with iron? _____ Yes / No

Is your child allergic to penicillin or other substances? _____ Yes / No

Does your child have an emotional or nervous condition? _____ Yes / No

Has your child ever had a history of: (please write "Yes" or "No" and elaborate below)

_____ Special Needs _____ Heart Murmur _____ Asthma _____ Bleeding Disorder

_____ Heart Trouble _____ Anemia _____ Diabetes _____ Rheumatic Fever

_____ Speech Problems _____ Tuberculosis _____ Kidney/ Liver Disorder

_____ Epilepsy/Convulsions _____ Any unusual conditions

If answered "Yes" to the question above, please explain _____



Dental History

Please answer applicable questions by circling and elaborate below if "Yes"

Does your child have any dental problems now? _____ Yes / No

Has your child ever been to a dentist before? _____ Yes / No

Was the visit a good experience? _____ Yes / No

If not Why? _____

Has your child ever had a dental X- Ray? _____ Yes / No

Has your child seen a dentist in the last 6 months? _____ Yes / No

Has your child ever had a toothache? _____ Yes / No

Has your child's teeth ever been injured in an accident? _____ Yes / No

Does your child have oral habits? (pacifier, thumb, finger, nail biting) _____ Yes / No

Do you help brush your child's teeth? _____ Yes / No

Does your child have a bottle with milk or juice? _____ Yes / No

Does your child fall asleep with a milk or juice bottle? _____ Yes / No

Do you nurse you child to sleep? _____ Yes / No

Does your child drink any sweet beverage between meals? _____ Yes / No

Does your child eat mints, candies, pastries, crackers etc. between meals? _____ Yes / No

Does your child drink milk and eat cheese/yogurt daily? _____ Yes / No

Has your child been getting systemic fluoride from water? _____ Yes / No / Don't Know

Has your child been getting topical fluoride from toothpaste or mouth rinse? Yes / No / Don't Know

To the rest of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or medicines, I will inform the doctors. I hereby authorize treatment by the doctors in caring for my child.

Signed: _____

Date: _____

Additional Comments:



Informed Consent

I hereby authorize and direct Dr. Mila Davis of Healthy Smiles Children's Dentistry, assisted by dental auxiliaries of her choice, to perform upon my child (or legal ward whom I consent) dental services that in their judgment are advisable child including the use of nitrous oxide analgesic gas, restraints such as papoose of my child for dental records with the exception of: _____

Although their occurrence is not frequent, some risks and complications are known to be associated with pediatric treatment include nausea, following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risk of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown or extracted tooth, injury to tongue, lips or cheek, damage to and the possible loss of existing teeth and or fillings, injury to nerves near the treatment site fracture to a tooth root which may require additional surgery for its removal.

I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in until such time that I choose to terminate it.

Signature: _____ **Date:** _____

Parent Guidelines:

Dear Parents,

You may choose whether or not you accompany your child to his/ her hygiene appointment. Although we sense that some children do better without parents present, we are open to having you with your child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

- 1. Allow us to prepare your child'**
- 2. Be supportive of the practice's terminology.**
- 3. Please be a silent observer-support your child with touches.**
 - A. This allows us to maintain communication with your child.**
 - B. Children will normally listen to their parents instead of us and may not hear our guidance.**
 - C. You might give incorrect or misleading information.**
- 4. If asked to leave, be ready to immediately walk away.**
 - A. Many children will try to control the situation.**
 - B. "Acting out" is normal, but unacceptable during fillings**
 - C. This is intended to "short circuit" the control attempt.**
 - D. We will continue to support your child at all times.**

These are very important ways that you can actively help in the success of your child's visit. We are confident that all will go well and hope these guidelines will prepare you with confidence for your child's upcoming appointment.

Signed: _____ **Date:** _____

Patient HIPAA Awareness

With my permission, Healthy Smiles Children’s Dentistry, may use and disclose protected health information (PHI) about me to carry out treatment , payment, and health care operations (TPO). Please refer Healthy Smiles Children’s Dentistry’s Notice of Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signings this consent. Healthy Smiles Children’s Dentistry reserves the right to revise the Notice of Privacy Practice at anytime. A revised copy may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Healthy Smiles Children’s Dentistry may call my home or other designated location and leave a message on a voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Healthy Smiles Children’s Dentistry may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements. I have the right to request that Healthy Smiles Children’s Dentistry restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if does, it is bound by this agreement.

By signing this, I am allowing Healthy Smiles Children’s Dentistry to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

Signature of Parent or Legal Guardian *Date*

Patients Name *Date*

Print Name of Parent or Legal Guardian *Date*

