Child Health / Dental History Form

Please complete the following information for your child - Both Page 1 and 2

Patient Name: ______________________________ Date: ___________
Last, First MI (Preferred Name)

Social Security #: ____________________ Birth Date: ____________________

Phone (Home): ____________ (Work): ____________ (Cell): ____________

Address: ______________________________
Street City State Zip Code

Emergency Contact: ______________________________
Name Phone Number Relationship

Child Medical History

Has your child ever had any of the following? Please check those that apply:

- ☐ Allergies __________ ___________________
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Bleeding Tendencies
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy/Convulsions
- ☐ Fainting Spells
- ☐ Glaucoma
- ☐ Growths/Tumors
- ☐ Head Injuries
- ☐ Heart Conditions
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Growths/Tumors
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Reaction to Anesthetic
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Steroid Therapy
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other Medical Condition Explain: ____________

Yes	No	
☐	☐	Has your child ever been admitted to a hospital? If so, for what? ____________
☐	☐	Is your child under active treatment by a physician? If so, for what? ____________
☐	☐	Is your child taking any drugs or medications? If so, what?____________
☐	☐	Is you child allergic or has he/she reacted adversely to any medications? If so, what? ____________
☐	☐	Has your child ever had a serious illness? If so, what? ____________

Child Dental History

Yes	No	
☐	☐	Does your child currently have teeth that are painful?
☐	☐	Has your child ever been to the dentist before? If not the first visit, what was the date of the last visit?____________
☐	☐	Has your child had any difficulties with dental treatment in the past? Please explain:____________
☐	☐	Has your child ever been sedated prior to dental treatment?
☐	☐	Has your child ever suffered any injuries to the mouth, head, or teeth?
☐	☐	Has your child previously had any orthodontic work performed (braces or space maintainers)?
☐	☐	Does your child suck his or her thumb or sleep with a pacifier?

Please circle the appropriate response

My child's teeth are brushed: not sure / occasionally / once daily / twice daily
My child brushers his/or her teeth: alone / with assistance from a parent
My child brushes with fluoridated toothpaste: yes / no / not sure

Reason for today's visit or any specific concerns: ______________________________

I certify that all health information above is correct: ____________________ ____________________
Parent/Guardian Signature Date Doctor Review Date

Referral Information

Whom may we thank for referring you to our practice?
☐ Another patient - Name: ____________ ☐ Another Dental Office - Name: ____________
☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other____________

Office Use – In the future, please advise us of any changes in your child's medical history or any new medications. ***Continue to P.2***

Date of Review:	Changes to child's health history?	Parent Initial:
____________	☐ Yes ☐ No	____________
____________	☐ Yes ☐ No	____________
____________	☐ Yes ☐ No	____________

Guarantor Information

Who is responsible for this account? ______________________________
Social Security #: ______________________ Birth Date: ______________________
Phone (Home): ____________ (Work): ____________ Ext: ______ Best time to call: __________
Address: ____
Street   Apartment #
____
City   State   Zip Code

Insurance Information (if applicable)

Primary Insurance
Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last   First   MI
Insured's Birth Date: ____________ Soc. Sec. #: ________________ Group #: __________
Insured's Address: ____
Street   City   State   Zip Code
Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________
Insurance Plan Name and Address: ____
____

Secondary Insurance
Name of Insured: ______________________________
Last   First   MI
Insured's Birth Date: ____________ ID #: ________________ Group #: ________________
Insured's Address: ____
Street   City   State   Zip Code
Insured's Employer Name: ____
Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________
Insurance Plan Name and Address: ____

Agreement and Consent for Services

Payment and Insurance
In consideration for the professional services rendered to me, I agree to pay the reasonable value of the services provided to the said Doctor or his assignee. I understand that financial arrangements must be made in advance of treatment; otherwise fees are due at the time of service. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for the payment of all dental services rendered. As a courtesy, insurance forms will be submitted to your insurance company without charge. Payment for treatment is still the patient's responsibility. Any insurer not paying within 60 days of submission of bill will be treated as past due and the patient will be billed accordingly. Please understand that dental insurance is your coverage, not ours, and we cannot guarantee any payments by your company. A service charge of 1 ½ % (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixty days from the date of service unless previously written financial arrangements are satisfied. I understand that the fee estimate listed for dental care can only be extended for a period of six months from the date of the patient examination. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Informed Consent
The benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some inherent risks associated with virtually any dental procedure including but not limited to: (1) Drug or chemical reaction. Dental materials and medications may trigger allergic or sensitivity reactions. (2) Long term numbness (paresthesia). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness. (3) Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a jaw joint disorder. (4) Sensitivity in teeth or gums. (5) Damage to teeth, gum, or bone structures. (6) Bleeding, swelling, infection. (7) Swallowing or inhaling small objects. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit and the benefit of my minor child or ward. By signing this for, I freely give my consent to allow and authorize Dr. Larsen to render the dental treatment necessary or advisable to my dental condition, including administering and prescribing all anesthetics and/or medications

While we follow procedural guidelines, which most often lead to a clinical success, just like in any other pursuit in health care, no procedural outcome can be guaranteed. Please feel free to ask questions in regard to any dental procedures that are recommended to you.

I have read the above conditions of payment and conditions of treatment and agree to their content.

______________________________ Date: __________ Relationship to Patient: ______________
Signature of patient, parent, or guardian

______________________________ Date: __________ Relationship to Patient: ______________
Signature of guarantor of payment/responsible party