Pediatric Dentistry

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Patient Medical and Dental History

Child's Name ☐ **Male** ☐ **Female**

Child's Nickname Date of Birth Age

Pediatrician Pediatrician's Phone Number

Who may we thank for referring you?

MEDICAL HISTORY:

Has your child experienced any of the following?:

	Yes	No
Autism	☐	☐
Anemia	☐	☐
Asthma, Lung Disease or Breathing Problems	☐	☐
Bleeding Problems, Hemophilia	☐	☐
Cerebral Palsy	☐	☐
Delayed Speech Development	☐	☐
Developmentally Delayed	☐	☐
Diabetes	☐	☐
Thyroid or Glandular / Endocrine Problems	☐	☐
ADHD / Behavioral or Learning Problems	☐	☐
Fainting Spells	☐	☐
AIDS, HIV Positive	☐	☐
Heart Condition, Murmur	☐	☐
Jaundice, Liver Disease, Hepatitis	☐	☐
Kidney Disease	☐	☐

	Yes	No
Ear Infections, Hearing Loss or Impairment	☐	☐
Special Needs, Mentally Handicapped	☐	☐
Psychiatric Problems	☐	☐
Seizures, Epilepsy	☐	☐
Rheumatic Fever	☐	☐
Sickle Cell Anemia	☐	☐
Frequent Headaches	☐	☐
Congenital Birth Defects	☐	☐
Arthritis, Auto-Immune or Connective Tissue Diseases	☐	☐
Cancer, Tumor, Leukemia	☐	☐
Frequent Infections	☐	☐
Eye Disease	☐	☐
Hypertension, High Blood Pressure	☐	☐
Any Other Medical History of Concern	☐	☐

_____

DENTAL HISTORY:

DO YOU HAVE A DENTAL RELATED CONCERN? YES ☐ NO ☐ If YES, Explain:_____

_____

Is your child experiencing any of the following?:

	Yes	No
Cleft Lip / Palate	☐	☐
TMJ/TMD Problems	☐	☐
Latex Allergy	☐	☐
Thumb / Finger / Pacifier	☐	☐
List Food or Medication Allergy_____		

	Yes	No
Problems Sleeping at Night	☐	☐
Snoring	☐	☐
Currently Using Bottle or Sippy Cup	☐	☐
Currently Nursing	☐	☐
Trouble Breastfeeding at Birth	☐	☐

Please list any medications, vitamins or health supplements your child is currently taking:

Please complete the following questionnaire as thoroughly as possible. The information will be valuable assistance to us in establishing meaningful communication with your child.

1. Will your child be a cooperative patient? Explain:

2. Favorite hobbies, games

3. Does your child have any pets?

4. Names of brothers and sisters

5. School and grade

PATIENT REGISTRATION

Responsible Party Information

Name_____
Address_____
City_____State_____
Zip_____Phone _____
E-mail_____

Occupation _____
Employer's Address_____
City_____State_____
Zip_____Phone _____
Date of Birth_____

Spouse's Name _____
Address(*if different*)_____
City_____State _____
Zip_____Phone_____
E-mail_____

Occupation_____
Employer's Address_____
City_____State_____
Zip_____ Phone_____
Date of Birth_____

Consent

The signature affixed below authorizes examination and treatment by Drs, Setzer, Cochran, Soares and/or Drs. Setzer, Cochran, Soares and their staff, and further, use of those procedures which in the judgement of the doctor are necessary during the delivery of dental care.

I understand that Drs. Setzer, Cochran, Soares PA, may not be a contracted provider for my insurance company, and that our office will be filing to my insurance company as a courtesy and expect their payment in 30 days. I recognize that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by the insurance company.

I hereby assign all dental and/or surgical benefits, to include major medical benefits to which I am entitled, including private insurance and other health plans to: ***Drs. Setzer, Cochran, Soares PA.*** *This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assigns to release all information necessary to secure the payment.*

Our ***Notice of Privacy Practices*** *provides information about how we use and disclose protected health information about you. The Notice contains a Patients Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.*

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment , or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in regards to your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 ***(HIPAA)****.*

May we request release of your child's medical records for our reference? Yes or No
May we forward information regarding your child's dental records to your primary care physician and /or Dentist? Yes or No

Signature_____ Date_____