MID-MICHIGAN PEDIATRIC DENTISTRY, P.C.

MEDICAL HISTORY

Patient's Name _____ Date _____

General state of health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor _____

Is child under a physician's care at this time? Yes ❑ No ❑

Physician's Name _____ Phone _____

Is child taking any drugs or medication at this time? Yes ❑ No ❑ Please list _____

_____

Is your child up to date with immunizations? Yes ❑ No ❑

Has your child ever been hospitalized or been in a hospital? Yes ❑ No ❑ Emergency Room? Yes ❑ No ❑

If yes, why? _____

Is your child allergic to any medicine (such as penicillin, aspirin, or novocaine)? Yes ❑ No ❑ _____

If so, what? _____

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

❑ **This child has never been diagnosed as having any of these conditions.**

Yes	No		Yes	No		Yes	No	
❑	❑	A.I.D.S. (H.I.V.)	❑	❑	Diabetes	❑	❑	Kidney Disease
❑	❑	Allergy	❑	❑	Emotional Disturbance	❑	❑	Learning Disability
❑	❑	Anemia	❑	❑	Epilepsy	❑	❑	Leukemia
❑	❑	Asthma	❑	❑	Eye Problems	❑	❑	Mental Impairment
❑	❑	Autism	❑	❑	Excessive Bleeding Problem	❑	❑	Nutritional Deficiency
❑	❑	Blood Disorder	❑	❑	Fainting	❑	❑	Rheumatic Fever
❑	❑	Blood Transfusion	❑	❑	Hearing Loss	❑	❑	Scarlet Fever
❑	❑	Brain Injury	❑	❑	Heart Disease	❑	❑	Sickle Cell Anemia
❑	❑	Cancer	❑	❑	Heart Murmur	❑	❑	Syndrome _____
❑	❑	Cerebral Palsy	❑	❑	Hemophilia	❑	❑	Other _____
❑	❑	Cleft Lip/Palate	❑	❑	Hepatitis			_____
❑	❑	Convulsions/Seizures	❑	❑	Jaundice			_____

Comments _____

_____

DENTAL HISTORY

Briefly explain why you brought your child for dental care. _____

Is today your child's first visit to a dentist? Yes ❑ No ❑ If no, give date of last visit _____

What was done for your child at that time? _____ Reaction? _____

Has your child ever sucked his/her fingers? Yes ❑ No ❑ thumb? Yes ❑ No ❑ or pacifier? Yes ❑ No ❑ Is the habit still active? Yes ❑ No ❑

Does your child have a toothache today? Yes ❑ No ❑ Explain _____

Was your child bottle fed? Yes ❑ No ❑ If yes, at what age was it completely stopped? _____

Is your water supply fluoridated? Yes ❑ No ❑ Does your child receive any fluoride supplements? Yes ❑ No ❑ _____

Does your child brush his/her own teeth? Yes ❑ No ❑ How often _____ Do you assist? Yes ❑ No ❑

Comments _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment: _____

_____

(OVER)

MID-MICHIGAN PEDIATRIC DENTISTRY, P.C.

Please help us by furnishing the following information. The information given will be used in strict confidence to prepare your child's clinical chart. These questions will help us to obtain a better understanding of your child and thus enable us to give your child a better health service.

PATIENT

Child's Full Name _____ Preferred Name_____

Date of Birth_____ Age_____ Sex_____ SS#_____

Name of Person(s) ☐ Parent ☐ Guardian with whom Patient resides:

_____

Street Address _____

City _____ Zip Code_____ Telephone_____

PARENTS / GUARDIANS

Father's/Guardian's Name _____ Marital Status _____

Address (if other than above) _____

Occupation _____ Employer _____

Business Phone _____ Dental Insurance Carrier _____

SS# _____ Date of Birth ____/____/____ Group/Policy # _____

Mother's/Guardian's Name _____ Marital Status _____

Address (if other than above) _____

Occupation _____ Employer _____

Business Phone _____ Dental Insurance Carrier _____

SS# _____ Date of Birth ____/____/____ Group/Policy # _____

FAMILY

Number of Brothers _____ Sisters _____ Have they been a patient in this office? _____

Family Dentist _____

Who may we thank for referring you to our office? _____

PAYMENT POLICY

The individual who accompanies the child to the dental office is responsible for all fees, irregardless of guardianship or custody arrangements.

PATIENTS WHO ARE NOT COVERED BY DENTAL INSURANCE:

All charges are expected to be paid in full at the time the dental services are rendered. Payment can be made by cash, check, Visa or MasterCard. If you ever have any questions about fees, please ask.

PATIENTS WHO ARE COVERED BY ANY DENTAL INSURANCE CARRIER:

Parents are requested to be prepared to pay their part of the dental services (co-pay) on the day the services are rendered for the patient. The dental office will complete our portion of any insurance form that is provided by the parent, and will forward the form to the insurance carrier for the parent. The parent, however, is responsible for the total fee and will be expected to make up for any deficiencies in the insurance coverage.

CONSENT FOR TREATMENT

I hereby authorize dental treatment for _____. This authorization includes procedures which are reasonable and customary for children's dentistry and deemed necessary. I also agree to pay the fees that are set for all treatment according to the payment policy set forth.

Signature_____ **Date**_____

PLEASE NOTE: When appointment time is reserved for you, it is reserved for you alone. **WE REQUEST 24 HOUR NOTICE IF YOU ARE UNABLE TO BE HERE.** No charge will be made for a missed appointment if this request is honored.

MID-MICHIGAN PEDIATRIC DENTISTRY, P.C.

Parent Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPPA") requires that this office comply with certain rules regarding the maintenance of the privacy of your child's health information that we have collected and will collect in the future.

To comply with one of HIPPA's requirements, we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPPA requires us to disclose regarding our privacy practices. This is not a change in our policies, but rather a formal declaration of them, as required under HIPPA.

Additionally, Michigan Law requires us to first obtain your written consent prior to disclosing any of your child's health information except for our disclosure in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your child's health information in connection with his/her treatment. For example, we may make a referral to or consult with another dentist or health care professional or otherwise make disclosures of your child's health information in connection with providing or coordinating his/her treatment.

Parent Acknowledgement

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Patient's (Children's) Name(s):

_____

_____

_____

_____

Patient/Parent's Signature:

_____

Date

_____