

Child Health/Dental History Form



American Dental Association
www.ada.org

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth	
Parent's/Guardian's Name			Relationship to Patient		
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>					
Phone <small>Home Work</small>			Sex M <input type="checkbox"/> F <input type="checkbox"/>		
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? If you answer yes to any of the three items above, please stop and return this form to the receptionist.					
Has the child had any history of, or conditions related to, any of the following:					
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sickle cell	
Please list the name and phone number of the child's physician:					
Name of Physician _____			Phone _____		

Child's History

		Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1.	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2.	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3.	<input type="checkbox"/>	<input type="checkbox"/>
4. How would you describe the child's eating habits? _____			
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5.	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized?	6.	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7.	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic?	8.	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?.....	9.	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?.....	10.	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?.....	11.	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired?.....	12.	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut?	13.	<input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses?	14.	<input type="checkbox"/>	<input type="checkbox"/>
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15.	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past?	16.	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed?	17.	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth?	18.	<input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth?	19.	<input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment?	20.	<input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water			
22. Does the child take fluoride supplements?	22.	<input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used?	23.	<input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24.	<input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier?.....	25.	<input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____			
27. Does child participate in active recreational activities?	27.	<input type="checkbox"/>	<input type="checkbox"/>

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist Comments _____ _____ _____ _____
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For Office Use Only: Medical Alert Premedication Allergies Anesthesia Reviewed by _____
Date _____

Higgs Family Dental BILLING & INSURANCE Policy

1. Patient Name: _____

Name of Responsible Party: _____ DOB: _____ SS# _____

Home: _____ Cell: _____ Work: _____

Address (if different from patient) _____

2. Insurance Information: (you may skip to #3 if you do not have Dental Insurance)

Employee Name: _____ SS# _____ DOB: _____

Employer Name: _____

Primary Dental Insurance Carrier: _____ Phone # _____

Secondary Ins Carrier (if applicable): _____ Phone # _____

Employer Name: _____

Employee Name: _____ SS# _____ DOB: _____

Your dental benefits are based upon a contract made between your employer, or agent, and an insurance company. If you have any questions regarding your dental benefits, please contact your employer, agent or insurance company directly. We estimate your portion based on the information provided by your insurance company, but it is only an **ESTIMATE**. We will bill your insurance company as a courtesy. If your insurance does not pay within 90 days, Higgs Family Dental reserves the right to collect payment from you, in full, for services and allow the insurance funds to be paid directly to you. Ultimately, you are responsible for all charges incurred in our office.

Initial here _____

3. How did you hear about our office?

family / friend office sign web / Social Media newspaper doctor

Who referred you to our office? _____

Appointment Reminder Preferences:

text ph# _____ email _____ phone _____

Previous Dentist Name: _____ Phone # _____

Preferred Pharmacy Name: _____ Phone # _____

Patient Signature: _____ Date: _____

STANLEY A. HIGGS, D.D.S., INC.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Appointment Coordinator

Telephone: 409-925-3549 Fax: 409-925-2931

Address: P.O. Box 741, 13125 Hwy 6

Santa Fe, Tx 77510

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

STANLEY A. HIGGS, D.D.S., INC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

{Please Print Name}

{Signature}

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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