Children's Dentistry
Decatur/Huntsville

Today's Date:_____

Patient's Medicaid Number: _____

PATIENT INFORMATION			
Patient's last name:	**First:**		**Middle:**
Home Phone:	**Cell phone:**	**Birthdate:**	**Age:**
Sex: ☐ **M** ☐ **F**			
Street Address:	**Social Security No:**		**Email Address:**
City:	**State:**		**Zip Code:**
Sports:	**School:**		**Grade:**
Native Language: ☐ **English** ☐ **Spanish** ☐ **Other:**			

(Please give your insurance card to the receptionist)

FATHER'S Name:	**Date of Birth:**	**SSN:**
Street Address: **Place of Employment:**	**City:** **Work Phone:**	**State/Zip Code:** **Home/Cell Phone:**
MOTHER'S Name:	**Date of Birth:**	**SSN:**
Street Address: **Place of Employment:**	**City:** **Work Phone:**	**State/Zip Code:** **Home/Cell Phone:**

Who has legal custody of this child? **Emergency Contact:**
Phone Number:

Person responsible for bill:	**Birthdate:**	**Address (if different):**	**Home phone (if different):**
Occupation:	**Employer:**	**Employer address:**	**Employer phone:**

Is this person covered by insurance other than Medicaid? ☐ **Yes** ☐ **No**

Primary Insurance Coverage:

Subscriber's name:	**Subscriber's SSN:**	**Birthdate:**	**Group number:**	**Policy number:**

Patient's relationship to subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

Secondary Insurance Coverage:

Subscriber's name	**Subscriber's SSN**	**Birthdate:**	**Group number:**	**Policy number:**

Patient's relationship to subscriber: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**

CHILDREN'S DENTISTRY
MEDICAL HISTORY UPDATE

PATIENT NAME: _____ **DATE OF BIRTH:** _____
PATIENT ADDRESS: _____ **PATIENT PHONE:** _____
_____

PATIENT INFORMATION:
Has there been any change in address or phone number? **Yes** **No**
If Yes, please write all updated information.)

INSURANCE
Has there been any change in insurance? (If Yes, please give card to receptionist) **Yes** **No**

GENERAL HEALTH HISTORY (Please check all that apply. List others below.)

ADD/ADHD	YES NO	AIDS/HIV1	YES NO	ASTHMA	YES NO	AUTISM	YES NO
BLOOD DISORDER	YES NO	CANCER	YES NO	CEREBRAL PALSY	YES NO	DEVELOPMENTALLY DELAYED	YES NO
DIABETES	YES NO	DOWN'S SYNDROME	YES NO	EMOTIONAL PROBLEMS	YES NO	EYE PROBLEMS	YES NO
EAR PROBLEMS	YES NO	HEART CONDITION	YES NO	HEPATITIS	YES NO	KIDNEY CONDITION	YES NO
LIVER CONDITION	YES NO	SICKLE CELL	YES NO	SEIZURES	YES NO	SPECIAL NEEDS	YES NO
SPEECH PROBLEMS	YES NO	STOMACH PROBLEMS	YES NO	TUBERCULOSIS	YES NO	FAINTING	YES NO
OTHER:							

MEDICAL HISTORY
Has there been any change in child's medical history? **Yes** **No** **If yes** _____

Does your child currently take any medications? **Yes** **No** **if yes** _____

Allergies:
Is patient allergic to any food, drugs, or latex: Please list others below.
Penicillin **Yes** **No**
Amoxicillin **Yes** **No**
Latex **Yes** **No**
Sulfa Drugs **Yes** **No**

Other: _____

PERSONAL HEALTH HISTORY
Does your child suck thumb, finger or pacifier? **Yes** **No**
Is your child currently breast or bottle feeding: **Yes** **No**
Does your child use a sippy cup? **Yes** **No**
Does your child drink soda? **Yes** **No**
Is your child currently seeing an orthodontist? **Yes** **No** **If yes** _____
Do you brush your child's teeth? **Yes** **No**
Does your child brush his/her own teeth? **Yes** **No**
Does your child use dentla floss? **Yes** **No**
Do you have flouride in your water system? **Yes** **No**
Are your child's immunizations up to date? **Yes** **No**
Is your child currently under the care of a physician? **Yes** **No** **If yes** _____
Has your child had any operations/hospitalizations? **Yes** **No** **if yes** _____

CHILD'S HEALTH AND PERSONAL SAFETY

Caffeine	Yes	No	Coffee	Yes	No	Tea	Yes	No
Alchohol	Yes	No	Tobacco	Yes	No	Cola	Yes	No
Drugs	Yes	No	If yes _____					

Name of local Friend or Relative:_____**Relationship:**_____**Phone:**_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in medical status. I am a parent, guardian or personal relative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I request and authorize the dental staff to perform necessary dental services for me/my child, including but not limited to xrays, and administration of anesthesia, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered. I authorize the dentist to release any information including diagnosis and records of treatment or examination rendered to me/my child during the period of such Dental care to third party payors/health practitioners.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN: _____

DATE: _____

CHILDREN'S DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

AS REQUIRED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 THIS PRACTICE MAY USE YOUR PERSONAL HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THE SPECIFIC USES AND DISCLOSURES THAT WE INTEND TO MAKE ARE DESCRIBED IN OUR NOTICE OF INFORMATION PRACTICES. YOU HAVE THE RIGHT TO REVIEW THE NOTICE OF INFORMATION PRACTICES PRIOR TO SIGNING THIS CONSENT FORM. YOU MAY REQUEST RESTRICTIONS ON THE USES AND DISCLOSURES DESCRIBED IN THE NOTICE OF INFORMATION PRACTICES BY REQUESTING THE "RESTRICTION REQUEST" FORM. YOU MAY REVOKE THIS CONSENT AT ANY TIME BY SIGNING AND DATING THE REVOCATION FORM. ALL FORMS ARE AVAILABLE BY REQUEST.

NO FILMING IS ALLOWED IN THE TREATMENT AREA AS PER THE PATIENT PRIVACY ACT. IF VIOLATED ALL PATIENTS AND THEIR LEGAL COUNCIL WILL BE NOTIFIED AND THE PERSON FILMING WILL BE SUBJECT TO DISMISSAL FROM THE PRACTICE.

CONSENT SECTION

I, _____HEREBY CONSENT TO THE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. MY "PROTECTED HEALTH INFORMATION" MEANS HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION, COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER, OR A HEALTH CARE CLEARING HOUSE. THIS PROTECTED HEALTH INFORMATION RELATES TO MY PAST, PRESENT, AND FUTURE PHYSICAL AND/OR MENTAL HEALTH CONDITION.

I UNDERSTAND THAT I MAY REQUEST RESTRICTIONS ON THE USES AND DISCLOSURES OF MY HEALTH INFORMATION AT ANY TIME. I FURTHER UNDERSTAND THAT DENTAL ASSOCIATES IS NOT REQUIRED TO ACCEPT MY RESTRICTION REQUEST.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME, IN WRITING, EXCEPT TO THE EXTENT THAT DENTAL ASSOCIATES HAS TAKEN ACTION IN RELIANCE ON THIS CONSENT.

I UNDERSTAND THAT MY SIGNATURE BELOW INDICATES THAT I HAVE BEEN GIVEN A COPY OF THE NOTICE OF PRIVACY PRACTICES TO REVIEW AND TO HAVE ANY QUESTIONS ANSWERED BEFORE SIGNING. DENTAL ASSOCIATES RESERVES THE RIGHT TO CHANGE THE PRIVACY PRACTICES THAT ARE DESCRIBED IN THE NOTICE OF PRIVACY PRACTICES. A REVISED NOTICE MAY BE OBTAINED BY CONTACTING THE OFFICE.

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY DATE

PLEASE LIST ANYONE THAT YOU AUTHORIZE TO BRING YOU/YOUR CHILD TO DENTAL VISITS AND ALLOW TO MAKE DECISIONS OR DISCUSS DENTAL CARE.

1. _____

2._____

3._____

4. _____

CHILDREN'S DENTISTRY

PATIENT NAME: _____ DATE OF BIRTH: _____

1. **FIRST VISIT: It is important that your child have a positive dental experience from an early age. We tailor your child's dental visit based on his/her age and comfort level.**

2. **If your child's Medicaid number changes, you MUST bring the new card with you to his/her dental visit. Failure to do so may result in having to reschedule the appointment.**

3. **You will be given a date & time for your child's appointment. It is very important to be at the appointment on time. Being late may result in having to reschudule the appointment. Repeated tardiness or breaking an appointment could lead to dismissal. Breaking an appointment means being more than 10 minutes late or cancelling the appointment with less than a 24 hour notice. We make every effort to contact you before your child's appointment to confirm but it is ultimately your responsibility.**

4. **PATIENTS *"MUST"* BE ACCOMPANIED BY AN ADULT OVER THE AGE OF 18 AT ALL TIMES. PATIENT'S *"MUST NOT"* BE LEFT ALONE AT THE OFFICE. *ADULT IS TO REMAIN IN THE BUILDING.* FAILURE TO COMPLY WILL RESULT IN DISMISSAL.**

5. **PARENTAL PRESENCE: Parents are invited to accompany their child during cleanings and treatment although we know some children do better without parents present. If you choose to be present, we ask that you be a silent observer. This allows us to maintain communication with your child while giving him/her our undivided attention.**

6. **SCHEDULING: We encourage morning appointments for children under 6 years of age since younger children are often more cooperative, alert, and happy earlier in the day.**

7. **TREATMENT AID: Occassionally we need to use aids that help us take care of your child. These services include:**
   ***Mouth Prop* - a device used to help childs mouth remain open**
   (the drawback to this device can be bruising to cheeks, dislodging of tooth, or laceration on lips)
   ***Nitrous Oxide* – a gas commonly known as laughing gas and can have conflicting side effects such as nausea or sleepiness (please avoid heavy meals or dairy products prior to the appointment)**
   ***Papoose Board* – a device commonly referred to as a blanket used to keep your child saft during dental procedures that keeps the child's head, arms and legs still**

Thank you for trusting us with the care of your child. Please do not hesitate to let us know if you have any special concerns. Communication is very important for effective and successful treatment.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION. I ALSO UNDERSTAND THAT THE ABOVE NAMED DEVICES MAY HAVE TO BE USED ON MY CHILD TO RENDER QUALITY DENTAL CARE. I HEREBY AUTHORIZE THE PERFORMANCE OF DENTAL SERVICES FOR THE PATIENT AND TO DO THE NECESSARY PROCEDURES DIAGNOSED BY THE DENTIST.

SIGNATURE: _____ DATE: _____