Medical / Dental History

Child's Name: _____ Birthday: _____
Please Print (*Last*) (*First*) (*MI*)

Is English your primary language? □ Yes □ No

Medical History

Child's Physician _____ Address _____ Phone # _____

Date of Last visit _____ Reason _____

Is your child in good physical health? □ Yes □ No
Is your child up to date with immunizations? □ Yes □ No
Is there any possibility your child could be pregnant? □ Yes □ No
Does your child have any physical/ mental/ muscular/ handicaps □ Yes □ No
Has your child been hospitalized since his/her birth? □ Yes □No
State law requires we ask.

Check any of the following that may pertain to your child:
Does your child need to be pre-medicated due to a medical condition? □ Yes □ No

□ heart Murmur	□ Epilepsy	□ Latex Allergy	□ Seizures
□ Brain Injury			
□ Heart Condition	□ Diabetes	□ Cancer	□ Learning Disability
□ Anemia			
□ Lung Condition	□ Cerebral Palsy	□ Tuberculosis	□ Handicaps
□ Rheumatic Fever			
□ Bleeding Problem	□ Sickle Cell Anemia	□ Asthma	□ Hearing Problems
□ RSV			
□ Liver Problem	□ Hepatitis	□ Allergies (seasonal)	□ Sight Problems
□ Other _____			
□ Kidney Problem	□ AIDS / HIV +	□ Sinus Problems	□ Blood Transfusion

Please describe any medical condition that was checked above:
_____
_____

Please list all medications that your child is taking:
_____

Is your child allergic to any medications? □ Yes □ No If yes, List
_____
_____

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www.ClarkPDG.com

Dental History

Reason Your Child is here today:

_____

Is your child in any dental discomfort today? □ Yes □ No

Is this your child's first dental visit? □ Yes □ No Date of last visit: _____
Were X-Rays taken? _____

Has your child had an unfavorable experience in a dental office? □ Yes □ No
If yes, Explain _____

Has your child experienced any unfavorable reaction to a local anesthetic or laughing gas? □ Yes □ No

Child's Previous Dentist _____ Address _____Phone # _____

What is your water source? □ Private well □ Public System

Does your child suck their thumb or finger?	□ Yes □ No
Has your child ever had trauma with their teeth?	□ Yes □ No
Does your child use a pacifier?	□ Yes □ No
Does your child have any history of speech problems?	□ Yes □ No
Was your child bottle fed?	□ Yes □ No
Have you or any children had orthodontic treatment?	□ Yes □ No

How do you assist your child with tooth brushing?

_____

Permission

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes to my child's medical status. A copy of Clark Pediatric Dental Group's Notice of privacy is available upon request.

Parent / Guardian's Signature _____ Date: _____

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Registration

Child's Name _____ Date of Birth _____ Sex: M/F

Child's Name _____ Date of Birth _____ Sex: M/F

Child's Name _____ Date of Birth _____ Sex: M/F

Child's Name _____ Date of Birth _____ Sex: M/F

Address _____
(Street) (City) (State) (Zip)

Parent / Guardian's E-mail Address _____

Home Phone _____ Cell _____

Mother's Name _____ DOB _____

Father's Name _____ DOB _____

Emergency Contact _____ Phone _____ Cell _____
(Closest relative or friend)

Who is authorized to bring the patient for dental treatment and authorized to sign consent for treatment?

_____

_____

We require a 24 hour notice for cancellation or the appointment will be broken. After 2 broken appointments no more appointments will be scheduled.

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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}

Additional individuals we can contact or release information to: _____

_____

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)

_____

_____

_____

Consent for Treatment and Financial Acknowledgement

I, the undersigned Parent/Legal Guardian of the patient, hereby authorize the undersigned provider Dr. Clark to perform the procedure(s) or course(s) of treatment that has been discussed. I understand my child's dental condition and have discussed several treatment options. I have been given printed consent forms of the procedures with treatment details.

I understand the risks inherent in the treatment(s). I have discussed these risks with the dentist. The dentist has addressed all questions and concerns I have presented. I understand the expected results of the procedure(s) or course(s) of treatment. I understand that these results cannot be guaranteed and may not be achieved. I am aware of my right to waive treatment of any kind and I am aware of the possible consequences of non-treatment.

I have disclosed my child's/children health history information, including allergies, reactions to medicine, diseases, and past procedures. I understand that withholding this information may affect the outcome of the procedure(s) or course(s) of treatment.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s) that were discussed. I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures to my child or children.

I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider.

I understand that any out of pocket expenses are based on insurance estimates and are subject to change. Any remaining balance not covered or downgraded by my insurance will be my responsibility.

Name of the patient/s: _____

Parent/Legal Guardian/s (Print): _____

Parent/Legal Guardian's Signature: _____ Date: _____

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Informed Consent

Permission for Dental Examination and/or Treatment of a Minor

I am the parent or guardian of _____

who is a minor child, and I do hereby authorize and consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of Dr. _____ and his/her associates, staff members, or agents, as he/she may deem necessary.

This authorization will remain in effect until cancelled in writing by me.

Parent Signature _____ Date _____

Witness _____