pediatric dentistry, psc

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Child's Name: _____
□ Male □ Female Birthday: _____ Social Security No: _____
Purpose of Visit: _____ Concerns: _____
Name and age of siblings: _____ Is your child adopted? □ Yes □ No
Does child have any special needs? _____ Any Phobias? _____

We have Therapy Dogs, Rosie (Golden Doodle) & Theo (Schnauzer), in our office. Please list any concerns you may have.

_____

Health History

Child's Pediatrician: _____ Immunization up to date? □ Yes □ No
List any medications your child is currently taking: _____
Is your child allergic to any medications? ____ If yes, please list: _____
Any history of hospitalization or surgery? _____ If yes, when _____
Does your child have allergic reaction to any of the following (Please check all that apply):

□ Peanuts/ Tree Nuts	□ Soy	□ Latex/Rubber	□ Pollen/Dust/Environmental	□ Anesthetics
□ Eggs	□ Metals	□ Animals	□ Berries	□ Acrylic
□ Milk	□ Wheat/Gluten	□ Dyes/Coloring	□ Other: _____	

ADHD/ADD	Y	N	Cardiac Disease/Heart	Y	N	Hepatitis	Y	N
Anemia	Y	N	Cerebral Palsy	Y	N	Immune Disorder	Y	N
Allergies	Y	N	Chemo/Radiation Therapy	Y	N	Kidney	Y	N
Arthritis/Joint Disorder	Y	N	Cystic Fibrosis	Y	N	Liver	Y	N
Asthma	Y	N	Delayed Development	Y	N	Murmur	Y	N
Allergies to Meds	Y	N	Depression/Anxiety	Y	N	Pre-Med for Heart	Y	N
Autism	Y	N	Diabetes	Y	N	Premature Birth	Y	N
Bladder	Y	N	Downs Syndrome	Y	N	Rheumatic Fever/Heart	Y	N
Bleeding Disorder	Y	N	Earaches/Infections	Y	N	Speech Disorder	Y	N
Bone Disorder	Y	N	Eating Disorder	Y	N	Sinusitis	Y	N
Brain Injury	Y	N	Emotional/School Problems	Y	N	TMJ Problems	Y	N
Bruising	Y	N	Epilepsy/Seizure	Y	N	Tuberculosis	Y	N
Cancer/Malignancy	Y	N	Hearing Impaired	Y	N	Visual Impaired	Y	N
Muscular Disorder	Y	N	Other: _____					

Dental History

Is this your child's first dental visit? _____ If no, previous dentist: _____
Date of last visit: _____ How was his/her experience? _____
Were any x-rays taken? □ Yes □ No Is the child having a toothache? _____
Has child had injuries to teeth, mouth or head? _____ If yes, describe: _____
Has your child done any of the following (past or present)? Please check all that apply: □ Pacifier
□ Thumb/Finger Sucking □ Lip Sucking □ Mouth-Breathing □ Snoring □ Teeth Grinding □ Nursing
□ Bottle Feeding
How may we help to make this visit a positive experience for your child? _____
_____

GENERAL INFORMATION

Father/Guardian (Full Name)_____ Birthdate: _____ SSN: _____
Mother/Guardian (Full Name) _____ Birthdate: _____ SSN: _____
Parents are: □ Married □ Divorced □ Single □ Widowed □ Partners
Child lives with: □ Both □ Mother □ Father □ Other
Home Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____
Father's Employer: _____ Father Cell Phone: _____
Occupation: _____
Mother's Employer: _____ Mother Cell Phone: _____
Occupation: _____
Email Address: _____
Emergency Contact: _____ Phone: _____

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in his/her professional judgement to render the best dental treatment for my child. 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 the office of any changes in my child's health status. I agree to allow anyone that I allow to bring my child to an appointment to give consent for anything necessary.

Signature: _____ Relationship: _____ Date: _____

INSURANCE INFORMATION

Do you have dental insurance for you child? □ Yes □ No
Father's Insurance Co: _____ Group No: _____
Address of Father's Insurance: _____
Mother's Insurance Co: _____ Group No: _____
Address of Mother's Insurance: _____

Kentucky Law (KRS 313.040) allows a Licensed Dental Hygienist to evaluate patients without the doctor being present in the office if the doctor has examined the patient within the last 7 months. I consent for my child to be seen under General Supervision and to all covered preventative care including radiographs, pit and fissure sealants and fluoride. **INITIAL**: _____

Financial Agreement

I hereby authorize the provider to release any information including diagnosis and records to the third-party payer and/or health care practitioners. I authorize and request my insurance to pay directly to the above-named provider. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that failure to keep this account current may result in the provider unable to provide additional services. Patients with insurance must provide accurate and complete insurance information. You will be required to pay your portion the day of the treatment.

SIGNATURE: _____ DATE: _____

PEDIATRIC DENTISTRY, PSC

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient(s) Name(s): _____

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:

PEDIATRIC DENTISTRY, PSC
NANCY CARTER MUSSETTER, D.M.D.
P.O. BOX 1587
ASHLAND, KY 41105

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: _____