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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:** \_\_\_\_\_

**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: \_\_\_\_\_  
\_\_\_\_\_