HELOTES PEDIATRIC DENTISTRY & ORTHODONTICS

Child's Name ____
Last Name First Name Middle Initial

□ Male
□ Female Age_____ Birthday___/____/____ Nickname_________ Hobbies________

Home Address ____
Street Apt # City State Zip Code

Mailing Address ____
Street Apt # City State Zip Code

Home Phone #__________________ Mom Cell#______________Dad Cell#____________

How did you hear about us?____

Email Address:____

PARENT' S INFORMATION

Circle One:
Father Stepfather Guardian
Name____________________________
Date of Birth:____/____/_____
Address (if different from patient)
____
Home Phone______________________
Work Phone______________________
Employer________________________
SSN#: __________________________

Do you have dental insurance coverage for a minor/child? YES NO

Circle One:
Mother Stepmother Guardian
Name____________________________
Date of Birth:_____/_____/_____
Address (if different from patient)
____
Home Phone_______________________
Work Phone_______________________
Employer_________________________
SSN ____________________________

Do you have dental insurance coverage for a minor/child? YES NO

PRIMARY INSURANCE

Subscriber Name:_____________________
Subscriber SSN#:____________________
Subscriber Date of Birth:___/___/_______
Insurance Co.________________________
Group #_____________________________
Policy/I.D. #_________________________

SECONDARY INSURANCE

Subscriber Name:_______________________
Subscriber SSN#:_______________________
Subscriber Date of Birth:__________/___/______
Insurance Co. _________________________
Group #______________________________
Policy/I.D. #__________________________

Patient Name: **Date of Birth:** **Date**

DENTAL HISTORY

Date of last visit to a dentist ___/___/____Last Cleaning___/___/____ Last X-Rays ___/___/_____
Reason(s) for seeking dental care:
_____First Examination _____Routine Check-Up _____Second Opinion
_____Toothache or Swelling _____Accident _____Other:_____________

Do you have any concerns or issues regarding your child's dental health that you would like to be addressed?

____

Has your child had any negative dental experiences? _____________If yes, please explain

____

How do you expect your child to react to the visit today?
_____Excellent ______Good ____Fair ______Poor ______Not sure

Is fluoride taken in any form? YES NO
__In vitamins ____In Water _____Drops/Tablets ______Rinse/Gel

Does your child brush teeth daily? YES NO

Does child floss every day? YES NO

Any injuries to mouth, teeth, head? YES NO
If yes, at what age?______Which teeth?_____________
What caused the injury?_________________________Treatment received?_______________

Any mouth habits? YES NO
_Thumb/Finger Sucking _Nail biting _Mouth Breathing __Pacifier __Sleeping with bottle
Other (please explain)____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?
Name_______________________Relationship______________Phone#_______________________
Name_______________________Relationship______________Phone#_______________________

PHOTO CONSENT

I ____________________, give consent for Helotes Pediatric Dentistry to capture a photographic imagery of my child ____________________, for their records. I understand that Helotes Pediatric Dentistry staff will have access to their photo in the dental record.

Patient/Guardian Signature_________________________ **Date**_______________________________________

Patient Name: ______________________ **Date of Birth:** ______________ **Date:** __________

CONSENT FOR TREATMENT

The information that I have given is correct and complete to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am the legal guardian of the patient.

I authorize the Dentist and Staff to perform the necessary dental procedures: complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), sealants, study models, and other diagnostic/preventive aids deemed necessary by the Dentist and the staff to make a thorough diagnosis of my child's dental needs.

I authorize the Dentist and Staff to provide any information to other Doctors (physicians, dentists, etc.) for the purpose of consultation. I understand that prior to providing any treatment, I will be advised about such treatment, that I may ask questions concerning the treatment, and that I may revoke this BEFORE treatment is provided. As the parent/legal guardian of the patient, I do hereby grant the dentist and the staff permission to perform any needed treatment(s).

Patient/Guardian Signature__________________________ **Date**______________________________

APPOINTMENT AUTHORIZATIONS

For future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information (must be 18yrs or older): Name of authorized person(s) to accompany my child for future treatment visits:

1. **NAME:**_ ____________________**_Relationship to Child:**____ ________________________
2. **NAME:**_ ____________________**_Relationship to Child:**____________________________

FINANCIAL AGREEMENT

- **Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company. We file your insurance claim as a courtesy to you.**
- **ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We ESTIMATE your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.**
- **If the insurance company doesn't pay within a 60 days, it is required that you pay the balance due.**
- **Your insurance card must be presented at every visit. If there is no insurance card, then payment (cash, check, or credit card) is expected at the time of service.**
- **I hereby authorize payment directly to Helotes Pediatric Dentistry, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.**

Patient/Guardian Signature______________________________ **Date**________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, ________________________________ have reviewed a copy of Helotes Pediatric Dentistry
(Parent or Legal Guardian's Name)
Notice of privacy Practices regarding my son/daughter ______________________________.

Patient/Guardian Signature ____________________________________ **Date** ______________________
OFFICE USE ONLY: __Patient Refused to Sign __Emergency Situation __Language Barrier __Other

Patient Name:____________________ **Date of Birth:**______________ **Date:**__________

CHILD'S MEDICAL HISTORY

Child's Physician____________________City/State____________Phone______________________________
Date of last physical exam______________Child's Vaccinations Updated YES NO
Current Medical Conditions____
Any other specialist your child is currently seeing:____

	Type:	Reason:	How often:
MEDICATIONS	____________	____________________	_______________
	____________	____________________	_______________
	____________	____________________	_______________

List of ALLERGIES (*LATEX*, MEDICINES, FOODS., ETC):_______________

	YES	NO	
Does your child have Congenital Heart Disease?	___	___	Is SBE prophylaxis required?__________
Is child receiving any medication or drugs?	___	___	List Medications_______________
Has child ever been hospitalized?	___	___	Is so, why?__________________
Has child ever had surgery?	___	___	List surgeries_________________
Is there excessive bleeding when cut?	___	___	Handicaps/Disabilities?___________

Does your child have, ever had or been diagnosed with any of the following (please check all that apply):

General
__Complications during pregnancy/birth
__Prematurity
__Cleft Lip/Palate
__Inherited Disorders
__Syndrome:______________
__Problems of growth or stature
__Currently Pregnant

Head, ears, eyes, nose, throat
__Chronic adenoid/tonsil infections
__Chronic ear infections
__Ear Problems
__Hearing Impairments
__Eye Problems
__Visual Impairments
__Sinusitis
__Speech impairments
__Apena/Snoring
__Mouth Breathing

Cardiovascular
__Heart Problem/Surgery
__Rheumatic Fever/Rheumatic heart disease
__High/Low Blood Pressure
__Heart Murmur

Respiratory
__Asthma
Medications__________
Last Attack__________
Hospitalizations________
__Frequent colds/coughs
__Reactive Airway Disease
__Tuberculosis
__RSV
__Breathing Problems
__Cystic Fibrosis
__Smoking

Endocrine
__Diabetes
__Growth Delays
__Hormonal Problems
__Precocious Puberty
__Thyroid Problems

Integumentary
__Fever blisters
_Eczema
_Rash/Hives
_Dermatologic Conditions
_Cold/Sores

Gastrointestinal
_Eating Disorders
_Ulcer
_Excessive Gagging
_Gastroesophageal/acid reflux disease
_Hepatitis A, B or C
_Jaundice
_Liver Disease
_Intestinal Problems
_Prolonged diarrhea
_Unintentional weight loss
_Lactose Intolerance
_Dietary Restrictions

Genitourinary
_Bladder Infections
_Kidney Infections
_Systemic Birth Control
__Sexual Transmitted Disease

Musculoskeletal
__Arthritis
_Scoliosis
_Bone/Joint Problems
_TMJ problems-popping/clicking/locking
_Problems opening mouth or chewing

Neurologic
_Fainting
_Dizziness
_Autism
_Developmental Disorders
_Learning Problems/Delay
_Mental Disabilities
_Brain Injury
_Cerebral Palsy
_Convulsions/Seizures/Epilepsy
_Hydrocephaly/Shunts

Psychiatric
__Emotional Disturbance
__Hyperactivity/ADHD/ADD
__Psychiatric problems/treatment
__Alcohol and chemical dependency

Hematologic/lymphatic/immunologic
__Anemia
__Blood Disorders
__Blood Transfusions
__Excessive Bleeding
__Bruising easily
__Hemophilia
__Sickle Cell Disease/Trait
__Cancer-Type:_________________
__Immune disorder
__Chemotherapy
__Radiation Therapy
__Bone Marrow Transplant

Infectious Disease
___Measles
___Mumps
__Rubella
__Varicella (Chickenpox)
__Mononucleosis
__Cytomegalovirus (CMV)
__Whooping Cough
__Scarlet Fever
__HIV/AIDS

Family History
__Genetic Disorders
__Problems with General Anesthesia
__Serious Medical Conditions/Illness

Social Concerns
__Passive Smoke Exposure
__Recreational Drug Use
__Religious or Philosophical objections to treatment

Other
____
____

I understand the information I have provided is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my child's medical status.

Parent/Legal Guardian Signature:______________**Relationship to Child:**_______________**Date:**_________