NORTH BROOKLYN PEDIATRIC DENTISTRY

Medical & Dental History, Consent & Privacy Policy

Tell us about your child

Today's Date: ______________________________

Child's Name: ______________________________

Birthdate: _____/_____/_____ Child's Age: _______

Preferred Name: _______________ ☐Male ☐Female

Child's Home #: ______________________________

Child's Home Address:

____

____

Who is accompanying the child today?

Name: ____________________ Relation: ______________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _______________

____

____

Other siblings seen by us: ___________________________

Previous/Present Dentist: ___________________________

Last Visit Date: ___________________________________

Parental Information

☐ **Mother** ☐ Step Mother ☐ Guardian

Name: ______________________________________

Birthdate: ____/____/____ Home # _______________

Work # _______________ Cell # _______________

SS#: ______________________________

Occupation: ______________________________

E-Mail: ______________________________

☐ **Father** ☐ Step Father ☐ Guardian

Name: ______________________________________

Birthdate: ____/____/____ Home # _______________

Work # _______________ Cell # _______________

SS#: ______________________________

Occupation: ______________________________

E-Mail: ______________________________

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated

Primary Dental Insurance

Policy Owner's Name: ______________________________

Relationship to Patient: ______________________________

Policy Owner's Birthdate: ____/____/____

Policy Owner's SS#: ______________________________

Insurance Co. Name: ______________________________

Insurance Policy ID #: ______________________________

Policy Owner's Employer: ______________________________

Insurance Co. Address: ______________________________

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Insurance Co. Phone #: ______________________________

Insurance Co. Group #: ______________________________

Secondary Dental Insurance

Policy Owner's Name: ______________________________

Relationship to Patient: ______________________________

Policy Owner's Birthdate: ____/____/____

Policy Owner's SS#: ______________________________

Insurance Co. Name: ______________________________

Insurance Policy ID #: ______________________________

Policy Owner's Employer: ______________________________

Insurance Co. Address: ______________________________

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Insurance Co. Phone #: ______________________________

Insurance Co. Group #: ______________________________

I certify that my child is covered by the above Insurance Co. and I assign directly to North Brooklyn Pediatric Dentistry all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____

Signature of parent or guardian Date

Why did you bring the child to the dentist today?

____

____

Has your child ever had a serious / difficult problem associated with previous dental work? ☐ Y ☐ N

If yes, please explain: ______________________________

____

Is the child's water fluoridated? ☐ Y ☐ N

Is the child taking fluoridated supplements? ☐ Y ☐ N

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Y ☐ N

Does the child brush his / her teeth daily? ☐ Y ☐ N

Floss his / her teeth daily? ☐ Y ☐ N

Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ☐ Y ☐ N

Child's Physician: ______________________________

Phone # ____________________ Date of last visit: ________

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all medications the child is currently taking:

____

____

Aside from items listed below, list all medications/things the child is allergic to:

____

____

Latex ☐ Y ☐ N Metals/ Nickel ☐ Y ☐ N

Plastic ☐ Y ☐ N

Has the child ever had any of the following medical problems?

☐ Y ☐ N Abnormal Bleeding

☐ Y ☐ N ADD / ADHD

☐ Y ☐ N Anemia

☐ Y ☐ N Any Hospital Stays

☐ Y ☐ N Any Operations

☐ Y ☐ N ArtificialBones/Joints/Valves

☐ Y ☐ N Asthma

☐ Y ☐ N Autism/Asperger's/PDD

☐ Y ☐ N Cancer

☐ Y ☐ N Chicken Pox

☐ Y ☐ N Congenital Heart Defect

☐ Y ☐ N Convulsions

☐ Y ☐ N Diabetes

☐ Y ☐ N Epilepsy

☐ Y ☐ N Exposed to HIV, but Neg.

☐ Y ☐ N Handicaps/Disabilities

☐ Y ☐ N Hearing/Vision Loss

☐ Y ☐ N Heart Murmur

☐ Y ☐ N Hemophilia

☐ Y ☐ N Hepatitis

☐ Y ☐ N Hives

☐ Y ☐ N HIV+ / AIDS

☐ Y ☐ N Kidney/ Liver Problems

☐ Y ☐ N Measles

☐ Y ☐ N Mononucleosis

☐ Y ☐ N Rheumatic/ Scarlet Fever

☐ Y ☐ N Sensory Issues

☐ Y ☐ N Sickle Cell Disease/Traits

☐ Y ☐ N Skin Rash

☐ Y ☐ N Tuberculosis (TB)

Are the child's immunizations current? ☐ Y ☐ N

Anything you would like to discuss with the Doctor in private? ☐ Y ☐ N

Please discuss any serious medical problem that the child has had: ______________________________

____

____

Does / did the child have any of the following habits?

☐ Y ☐ N Lip Sucking / Biting ☐ Y ☐ N Nursing Bottle Habits

☐ Y ☐ N Nail Biting ☐ Y ☐ N Thumb/Finger Sucking

Was the child breast fed? ☐ Y ☐ N

I understand that the information that I have given is correct to the best of my knowledge, that 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 authorize the dental staff to perform the necessary dental services my child may need.

____

Signature of parent or guardian Date

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.

____

Signature of parent or guardian Date

_____ Individual refused to sign