# Child Patient Health History

## Child information

Your Child: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Birth Date: _____

Phone (Home): _____ School: _____Grade: _____

## Health Information

**Has your child ever had any of the following? Please check those that apply:**

**MEDICAL HISTORY**

- ☐ ADHD or other neurologic condition
- ☐ AIDS/HIV
- ☐ Allergies _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autoimmune Disorders
- ☐ Behaviorial or conduct issues
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Easy Bruising
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Eye Disorders
- ☐ Frequent urination
- ☐ GI disorders / reflux / ulcers /abdominal pain
- ☐ Handicaps/ Disabilities
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur / MVP
- ☐ Hepatitis / Jaundice
- ☐ Hives or a skin rash
- ☐ Inflammatory joint disorder
- ☐ Immune Disorders
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disorders
- ☐ Migraine headaches
- ☐ Persistant Cough
- ☐ Shortness of breath after mild exercise
- ☐ Sinus trouble
- ☐ Speech delay
- ☐ Tuberculosis

**DRUG ALLERGIES**

- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Other Drug Allergies

**ALLERGIC REACTIONS**

- ☐ Local Anesthetics
- ☐ Latex
- ☐ Aspirin or other analgesics
- ☐ Sedatives

Has your child ever had abnormal bleeding with previous extractions, surgery, or trauma? ☐ Yes ☐ No

Has child had surgery or x-ray treatment for a tumor, growth, or other conditions? ☐ Yes ☐ No

Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

Is your child under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

Name of Physician: _____ Phone: _____

☐ Prescribed Medications:_____

Does your child have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Date of Last Dental Visit: _____ Reason for that visit: _____

Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Does your child currently have braces or wear a retainer? ☐ Yes ☐ No Planned date of braces removal _____

What past dental experiences has your child had?_____

Please let us know any other information that may help us to provide your child with optimum dental care:

_____

## Consent for Services

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my child's health. It is my responsibility to inform your office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/ or other health practitioners.

_____ Date: _____ Relationship to Patient: _____
Signature of Parent or Guardian

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# Child Patient Registration

**Primary Parent/Guardian Information** (*Must be able to legally sign for child)*

Name: _____ ____ _____
First MI Last

Birthdate: _____ SS# _____
month/day/year

□Male □Female

□Single □Married □Divorced □Widowed □Separated

| Mailing Address: |
|---|
| |

City State Zip

| Physical Address (if different): |
|---|
| |

City State Zip

Employer: _____How Long? _____

Telephone Contact Numbers

| | |
|---|---|
| Home: | Work: |
| Mobile: | Other: |

**Secondary Parent/Guardian Information**

Name: _____ ____ _____
First MI Last

Birthdate: _____ SS# _____
month/day/year

□Male □Female

□Single □Married □Divorced □Widowed □Separated

| Mailing Address: |
|---|
| |

City State Zip

| Physical Address (if different): |
|---|
| |

City State Zip

First MI Last

Telephone Contact Numbers

| | |
|---|---|
| Home: | Work: |
| Mobile: | Other: |

**Child's Information**

1) Name: _____ ____ _____
First MI Last

Preferred Name/Nickname: _____
Birthdate: _____ Age: _____ Grade: _____
month/day/year

SS# _____ □Male □Female
Child lives with: □Both parents □Mother □Father □Other:

2) Name: _____ ____ _____
First MI Last

Preferred Name/Nickname: _____
Birthdate: _____ Age: _____ Grade: _____
month/day/year

SS# _____ □Male □Female
Child lives with: □Both parents □Mother □Father □Other:

3) Name: _____ ____ _____
First MI Last

Preferred Name/Nickname: _____
Birthdate: _____ Age: _____ Grade: _____
month/day/year

SS# _____ □Male □Female
Child lives with: □Both parents □Mother □Father □Other:

4) Name: _____ ____ _____
First MI Last

Preferred Name/Nickname: _____
Birthdate: _____ Age: _____ Grade: _____
month/day/year

SS# _____ □Male □Female
Child lives with: □Both parents □Mother □Father □Other:

5) Name: _____ ____ _____
Employer: _____ How Long? _____

Preferred Name/Nickname: _____
Birthdate: _____ Age: _____ Grade: _____
month/day/year

SS# _____ □Male □Female

Child lives with: □Both parents □Mother □Father □Other:

*Please indicate the contact numbers that we have permission to leave a detailed message:*
□NONE □Home □Work □Mobile □Other

Email:

*Can we email you appointment reminders?* □Yes □No

*Who may legally sign for the minor child(ren) listed above (must be a parent or legal guardian):*
□ Primary Parent listed above □Secondary Parent listed above □Other:

*Who may we THANK for referring you?* _____

**Dental Insurance Information**

| Primary DENTAL Insurance | Secondary DENTAL Insurance |
|---|---|
| Insurance Company | Insurance Company |
| Insurance Phone Number | Insurance Phone Number |
| Policy Holder's Name | Policy Holder's Name |
| Group Number | Group Number |
| Policy Holder's Address (if different from above)<br>_____<br>_____ _____ _____<br>City State Zip | Policy Holder's Address (if different from above)<br>_____<br>_____ _____ _____<br>City State Zip |
| Policy Holder's Phone Number | Policy Holder's Phone Number |
| Policy Holder's Relationship to Patient<br>□Self □Spouse □Parent □Other: | Policy Holder's Relationship to Patient<br>□Self □Spouse □Parent □Other: |
| Policy Holder's Birth date | Policy Holder's Birth date |
| Policy Holder's SS# | Policy Holder's SS# |
| Insured's Employer | Insured's Employer |

# DENTAL PARENTAL INFORMED CONSENT FORM

CHILD'S NAME:_____ BIRTH DATE: _____

Your child has recently, been examined by Dr. McConnell and is in need of some basic dental care. This form will explain the care that your child needs, and requests your permission to provide that care. If the form is not returned, your child will receive no restorative dental care other than emergency care to relieve immediate pain. (Note the original consent form allows preventive care only) This information is provided to help you understand the treatment needed for your child. Before beginning, the following explanation of treatment is provided so that you are well informed and confident that you wish to proceed.

Treatment Plan

_____

_____

_____

☐ Dental Fillings:

Decay dissolves the tooth and, if not treated, will result in an abscessed tooth causing pain and infection. The dentist will remove the decayed and weakened part of the tooth and replace it with a silver alloy or tooth colored material to strengthen the tooth. A local anesthetic will be used that will "numb" the area being treated for two or three hours. If the decay area is too large, it may require a Stainless Steel Crown. I understand the placement of fillings may render the involved teeth sensitive to hot and cold temperatures and / or pressure for an extended period of time.

☐ Stainless Steel Crown:

If a tooth is badly destroyed by decay and / or a filling will not stay in place. The tooth is trimmed around the sides and a preformed crown or "cap" is placed over the tooth to protect it from breaking. As with fillings, the area is usually treated with an anesthetic to help the child remain comfortable for one or two hours. Stainless Steel Crowns are silver in color. The tooth and gum tissue afterwards may be sore after stainless steel crown placement. You may give the child Tylenol and supervise warm salt water rinses as needed. Please stay away from sticky candies as this may pull off the crown.

☐ Nerve or Pulp Treatment:

When the decay or infection progressed far enough that the tissue inside the tooth is infected, all or part of that infected tissue must be removed and a special filling placed in order to keep the infection from spreading to other parts of the body. The treatment can take up to two visits during which an anesthetic will be used. Pain or swelling after this work is possible and usually minor. Antibiotics may be used to control possible infections. After treatment, a filling or stainless steel crown will be placed to help strengthen the tooth and keep it from breaking.

☐ Sealants

Back teeth have deep grooves and pits in which decay usually starts. The dentist or assistant will "seal" the grooves with a plastic coating to help prevent the decay from starting. No anesthetic is needed.

☐ Extraction or Removal of the Tooth:

If the infection has spread too far to rebuild the tooth, it is often best to remove the tooth to prevent the infection from spreading. After "numbing" the area with anesthesia, the tooth is removed and gauze is placed. Biting on gauze usually will stop the bleeding. Pain or swelling after this work is possible and usually minor. Nothing carbonated for 48 hours. No vigorous rinsing for 48 hours.

☐ I understand that should the patient become uncooperative during dental procedures with movement of head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and or control leg movements. Procedure may not be continued or completed if safety and cooperation cannot be maintained. Your child may need to be referred to a specialist which is your responsibility.

☐ I understand that the administration of local anesthetic may cause an untoward reaction of side effects, which may include, but are not limited to temporary bruising, hematoma, cardiac stimulation, muscle soreness or rarely, permanent numbness.

☐ I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatments procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward.

☐ I consent to the above treatment plan after having been advised of the alternate plans of treatment available, the known material risks of the treatment to be used and the consequences if this treatment were withheld.

*If you have any questions regarding the care needed your child, please call the office at 812-476-3002 and they will be happy to answer your questions. There may be minor changes once treatment has been started. You will be notified of only major changes.

As the parent or guardian, by signing below you authorize Dr. McConnell and dental auxiliary to provide these services for the child named. If the form is not returned, no care will be given except emergency care.

I further acknowledge and attest that I have full legal authority to authorize and consent to the foregoing in the patient's best interest. This consent will be valid for one year from the date of signature.

Legal Guardian_____ Date_____

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# Permission to Share Medical/Dental Information

At Heritage Family Dental, we understand that the privacy of your personal information is important to you. Therefore, we will not discuss appointment dates/times, treatments or procedures, financial information, or any other personal information with anyone but you and those parties associated with your direct treatment (other medical/dental professionals, their treatment teams, and your insurance company), unless you give us written authorization to do so.

*Please initial next to your choice. More than one may be selected.*

____ I authorize my medical and dental information to be obtained and/or exchanged with the following individual(s) without restriction.

| Name | Relationship |
|---|---|
| | |
| | |
| | |

____ In the event of an emergency, I authorize the following individual(s) to be contacted. My medical and dental information is to be obtained and/or exchanged only for the purpose of notifying the authorized individual.

| Name | Work# | Home or Cell# | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

____ In the event Heritage Family Dental cannot reach me at my listed phone numbers, they may also call the following individual(s) to relay a message to me.

| Name | Contact# | Relationship | May we leave a detailed message? | Message Restrictions |
|---|---|---|---|---|
| | | | Yes / No | □Please call the office<br>□Appointment reminder<br>□Other: |
| | | | Yes / No | □Please call the office<br>□Appointment reminder<br>□Other: |
| | | | Yes / No | □Please call the office<br>□Appointment reminder<br>□Other: |

____ I DO NOT authorize any information to be obtained and/or exchanged with any individual.

*These authorizations may be modified or changed at anytime with written consent from the patient only.*

*The authorizations on this form expire automatically after one year at which point, a new form must be completed. Upon expiration, NO medical or dental information will be obtained and/or exchanged with any individual.*

_____ _____

Patient (Parent or Legal Guardian) Signature Date


# Heritage Family Dental Privacy Notice

***This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.***

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 812-476-3002.

*Information We Collect About You*

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide.
During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

*How Your Information Is Used*

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Heritage Family Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

*Safeguarding Your Personal and Health Information*

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Heritage Family Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Heritage Family Dental.

*Changes to Our Privacy Policy*

All new patients will review a copy of our privacy policy. Heritage Family Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

*Your Right to Restrict Use of Information*

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

_____ _____

Patient (Parent or Legal Guardian) Signature Date

_____

Patient Name (Please Print)

Heritage
Family Dental, P.C.

# Office Policies

**I have reviewed the Policies listed below and agree to comply with these policies as a requirement for me to continue as a patient with Heritage Family Dental.**

□ *I decline receiving a copy of these policies for my personal records.*
□ *I would like a copy of these policies for my personal records.*

***Initial* the following Policies reviewed**

_____ About your dental insurance
_____ Appointment Policy
_____ Comprehensive Care Philosophy
_____ Financial Policy
_____ HIPAA

_____ _____ _____
*Patient/Guardian (Print Name)* *Patient/Guardian Signature* *Date*