



Pediatric Medical History

Patient's full name: _____ **Date of birth:** _____

Male Female Pronouns: _____ Preferred name: _____

How did you hear about us? _____

Is this your child's first dental visit? yes no Previous dentist: _____

Date of last visit: _____

Do you have any concerns about your child's teeth? _____

Does your child have any habits? thumb/finger sucking pacifier grinding/clenching nail biting

Has your child had an unpleasant experience or unfavorable reaction to previous dental treatment? yes no

Please explain, if yes: _____

Who is responsible for brushing your child's teeth? child parent/caregiver

How often is your child brushing? AM PM both less than 1x daily not brushing

How often is your child flossing? 1x daily 1-3x weekly infrequently not flossing

Does your child use fluoride toothpaste? yes no If no, what kind? _____

Has your child had fluoride treatments before? yes no Prescription fluoride supplements? yes no

Does your child eat a well-rounded diet? yes no

What does your child drink? water milk juice soda energy drinks other: _____

Is your child currently breastfeeding? yes no

Does your child have anything to drink in their bed at night? nothing water other: _____

How many snacks per day does your child have? 1-2 3+ tends to snack all day long

Child's pediatrician: _____ Date of last visit: _____

Does your child see any specialists? yes no

If yes, please list who and why? _____

Is your child up to date on immunizations? yes no some, but not all

Does your child have any of the following allergies? Amoxicillin/penicillin Sulfa Latex NSAIDs Dyes

Acetaminophen Other: _____

Does your child have any food allergies? no yes: _____

Has a doctor ever prescribed an antibiotic prior to dental treatment? yes no

Please list any medications your child is taking: _____

Has your child had any surgeries? If so, please list: _____



Does your child have, or have they ever been diagnosed with, any of the following? Check all that apply.

- | | |
|--|--|
| <input type="checkbox"/> Complications at birth | <input type="checkbox"/> Skin problems / eczema |
| <input type="checkbox"/> Premature birth (weeks ____) | <input type="checkbox"/> Cold sores / fever blisters |
| <input type="checkbox"/> Genetic condition/syndrome | <input type="checkbox"/> Infectious diseases (HIV, MRSA, CMV, STD, TB) |
| <input type="checkbox"/> Cleft lip / palate | |
| <input type="checkbox"/> Growth problems | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Nutritional deficiency | <input type="checkbox"/> Hearing problems |
| | <input type="checkbox"/> Developmental delays |
| <input type="checkbox"/> Congenital heart defect | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Heart disease / rheumatic fever | <input type="checkbox"/> Brain injury |
| <input type="checkbox"/> Irregular heartbeat / murmur | <input type="checkbox"/> Epilepsy / seizures |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Autism / sensory processing disorder |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Hydrocephaly / shunt placement |
| | <input type="checkbox"/> Frequent headaches / migraines |
| <input type="checkbox"/> Chronic ear infections / sinusitis | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Frequent sore throat | |
| <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Behavioral / psychiatric problems |
| <input type="checkbox"/> Snoring / sleep apnea | <input type="checkbox"/> History of abuse or neglect |
| | <input type="checkbox"/> ADD / ADHD |
| <input type="checkbox"/> Asthma (triggers: _____) | |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Early onset puberty, hormonal problems |
| <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Thyroid / pituitary problems |
| <input type="checkbox"/> Frequent cough, cold, bronchitis | <input type="checkbox"/> Diabetes |
| | |
| <input type="checkbox"/> Jaundice, hepatitis, liver problems | <input type="checkbox"/> Hemophilia, excessive bleeding or bruising |
| <input type="checkbox"/> Kidney or urinary problems | <input type="checkbox"/> History of blood transfusion |
| <input type="checkbox"/> GERD / reflux | <input type="checkbox"/> Anemia, blood disorders |
| <input type="checkbox"/> Intestinal problems | |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Tumor, cyst, growth |
| | <input type="checkbox"/> Radiation treatment/chemotherapy |
| <input type="checkbox"/> Muscle, bone, or joint problems | <input type="checkbox"/> Bone marrow, stem cell, or organ transplant |
| <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Cancer |

Does your child have any medical conditions that are not listed here? If so, please list: _____

Parent/Guardian Information

Father:

Mother:

Step parent:

Legal guardian:

Married Single Divorced Widowed

Home address of responsible party:

City and **zip code**:

Work phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Insurance Information

Insurance company and employer:

Subscriber/Policy holder's name:

Relationship to child:

Subscriber/Policy holder's DOB:

Subscriber/Policy holder's social security #:

(If your child has Colorado health OP, list their social security number).

ID #: _____

Group #: _____

Does this child have Medicaid? yes no

Medicaid #: _____

Secondary Insurance Information

Insurance company and employer:

Subscriber/Policy holder's name:

Relationship to child:

Subscriber/Policy holder's DOB:

Subscriber/ Policy holder's social security #:

(If your child has Colorado health OP, list their social security number).

ID #: _____

Group #: _____

Authorization

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that payment is due at the time services are rendered. I hereby authorize payment directly to Littleton Kids Dental and Orthodontics from any insurance company listed above. I agree to the payment of any co-pays, deductibles, and uncovered services or amounts. I authorize the release of any dental information necessary to process insurance claims or for determination of benefits. If my account requires servicing for collection, I understand that I will be liable for all fees incurred.

Signature: _____

Today's date: _____

Vital information about your Dental Insurance

Insurance companies set their own schedules, and each company uses a different set of fees they consider allowable. When estimating dental benefits, deductibles and percentages must be considered. If we have received all of your insurance information and you have kept us current on any insurance changes, we will be happy to file the claim for you. Please be familiar with your insurance benefits, as this is a contract between you and the insurance company. At the time of service, we will collect from you the estimated portion that insurance is not expected to pay. By law your insurance is required to pay each claim within 30 days of receipt. We file insurance claims electronically, so your insurance company will receive each claim within days.

Cancellation policy

Cancellations require a 24 hour notice. We reserve the right to charge \$25.00 per child for not giving such notice. While we understand that circumstances happen that can cause you to cancel, please understand that we cannot fill a cancelled spot last minute.

Consents for treatment and release of information

I give the doctor permission to use such measures as deemed necessary in his/her professional judgment to render a diagnosis for my child and to perform treatment. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I understand that dental treatments are meant to help save my child's teeth, but it is not guaranteed. When a treatment plan is put together, I understand that treatment may not go in order of the written plan. I understand treatment is done in the order that is best for the patient and that treatment may change if necessary once a procedure has started.

I have given an accurate report of my child's physical and mental health history. I have also reported any proper allergic or unusual reactions to drugs, food, skin or any other physical conditions that my child's medical doctor has advised me should be reported to the dentist.

I understand and consent to x-rays and other protected health information being sent via email for the purpose of referrals, treatment and collection from insurance.

Responsible party signature: _____ Date: _____

Acknowledgement of receipt of Notice of Privacy Practices

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to the U.S. Department of Health and Human Services.

I, _____ (check one of the following)

- I have read and I have received a copy of this office's Notice of Privacy Practices
- I have printed and signed a copy of this office's Notice of Privacy Practices from the Littleton Kids Dental and Orthodontics website.
- I have read this office's Notice of Privacy Practices and do not wish to have a copy.

Signature: _____ Date: _____

-Below is for office use only-

- Individual refused to sign Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement Other (specify)



Appointment Policies

Late Appointment Policy

Please arrive on time to your scheduled appointment. Late arrivals cause schedule delays for those patients who arrive promptly for their appointment. Late arrivals will be worked in if time allows or rescheduled to another day.

Cancelled Appointment Policy

We ask that you make every effort to give us at least a **24-hour notice** if you cannot make your scheduled appointment. **If you are unable to give this notice, you will be charged \$25 for the missed appointment of a routine visit (cleaning/orthodontic adjustment), and \$75 for anything defined otherwise.**

When you give us a 24-hour notice, your reserved time can be made available for another patient. When patients do not show up for their appointment or do not give us adequate cancellation notice, we are not given the opportunity to reschedule that time with another patient who has a true dental need.

Thank you for understanding the value of our cancellation policy to each of our patients.

I understand and agree to the late appointment and cancelled appointment policies.

Patient's Full Name

Parent / Guardian

Date