Healthy Smiles Pediatric Dentistry P.C.
490 Buckland Road
South Windsor, CT 06074
Phone: (860)875-0769 **Fax**: (860)875-7101
Email: Care@healthysmilespd.com

Information and Health Form

CHILD'S NAME: _____ DATE BIRTH: _____ SEX _____

PARENT/LEGAL GUARDIAN INFORMATION

(PLEASE FILL OUT BOTH SECTIONS)

☐MOTHER ☐FATHER ☐GUARDIAN

PARENT/GUARDIAN MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED ☐WIDOWED

NAME: _____ BIRTH DATE: _____ SOCIAL SECURITY#: _____

ADDRESS: _____
STREET CITY STATE ZIP

CELLPHONE: _____ HOME PHONE: _____ EMAIL: _____

EMPLOYER: _____ ADDRESS _____
STREET CITY STATE ZIP

DENTAL

INSURANCE: ☐YES ☐NO COMPANY NAME : _____ MEMBER ID: _____

☐MOTHER ☐FATHER ☐GUARDIAN

NAME: _____ BIRTH DATE: _____ SOCIAL SECURITY#: _____

ADDRESS: _____
STREET CITY STATE ZIP

CELLPHONE: _____ HOME PHONE: _____ EMAIL: _____

EMPLOYER: _____ ADDRESS _____
STREET CITY STATE ZIP

DENTAL INSURANCE: ☐YES NO ☐ COMPANY NAME: _____ MEMBER ID: _____

REFERRED BY _____

MEDICAL HISTORY

Child's Physician:_____ Phone:_____ Date of last visit:_____

Address:_____
Street City State Zip

1. Is your child currently under medical care for an ongoing health condition? ☐Y ☐N If yes, please explain:

_____

2. Is your child currently taking any medications? ☐Y ☐N If yes, please list and explain:

_____

3. Has your child ever had a serious illness or surgery? ☐Y ☐N If yes, please explain:

_____

Please check boxes that apply

4. Does he/she bruise easily? ☐Y ☐N
5. Does he/she have any blood disorders? ☐Y ☐N
6. Has he/she ever had surgery, x-ray or chemotherapy for a tumor or growth? ☐Y ☐N
7. Does your child urinate more than six times a day? ☐Y ☐N
8. Is your child thirsty much of the time? ☐Y ☐N
9. Is he/she taking any of the following?

Antibiotics ☐Y ☐N
Blood thinners ☐Y ☐N
Cortisone or steroids ☐Y ☐N
Tranquilizers ☐Y ☐N
Dilantin or other anticonvulsant ☐Y ☐N
Insulin, Orinase, or similar drug ☐Y ☐N
Vitamins ☐Y ☐N
Other: _____

10. Is he/she **ALLERGIC** to any of the following?

Antibiotics ☐Y ☐N Latex ☐Y ☐N
Barbiturates or sedatives ☐Y ☐N
Local anesthetic ☐Y ☐N
Other:_____

11. Does your child have any of the following health conditions?

☐ Rheumatic heart disease
☐ Cystic fibrosis
☐ Congenital heart disease/ heart murmur
☐ Cardiovascular disease
☐ Allergy? food-medicine- other
☐ Asthma
☐ Hives or skin rash
☐ Seizures
☐ Hepatitis or liver disease
☐ Diabetes
☐ Arthritis
☐ Stomach ulcers
☐ Chronic ear infections
☐ Kidney disease
☐ Persistent cough
☐ Epilepsy
☐ Cancer/Tumor
☐ Sickle Cell disease
☐ Thyroid disease
☐ HIV+/AIDS
☐ Psychiatric treatment
☐ Cleft lip/palate
☐ Cerebral palsy
☐ Intellectual disability or difficulty
☐ Painful or swollen joints
☐ Hearing/ speech disability
☐ Developmental disability
☐ Hay fever
☐ Tuberculosis
☐ Other:_____

ADOLESCENT WOMEN:

12. Do you suspect that you are pregnant? ☐Y ☐N Are you taking birth control? ☐Y ☐N

DENTAL HISTORY

13. Is your child currently having problems with any of the following?

☐ Cavities	☐ Toothache	☐ Sensitive teeth	☐ Trauma
☐ Gum Infection	☐ Color of teeth	☐ Tooth alignment	☐ Other_____

14. Did child sleep with a bottle? ☐Y ☐N If yes, until what age? _____
15. Is child still nursing? ☐Y ☐N
16. Did child use pacifier? ☐Y ☐N If yes, until what age? _____
17. Was child a thumb/finger sucker? ☐Y ☐N If yes, until what age? _____
18. Does your child take fluoride drops, pills, or fluoride in your water supply? ☐Y ☐N If yes, what form:_____
19. Has he/she had any serious problems associated with previous dental treatment? ☐Y ☐N If yes, please explain:_____
20. Is this your child's first dental visit? ☐Y ☐N

Name of Office:_____ Phone_____

21. Last date of examination:_____ Were any x-rays taken? ☐Y ☐N
22. Do any of the close family members have personal experience with or currently have any untreated cavities? ☐Y ☐N
23. Has he/she ever have orthodontic treatment? ☐Y ☐N

    Name of Office:_____Phone:_____
24. Does he/she grind or clench teeth? ☐Y ☐N

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health medications, I will inform the doctor at the next appointment. All professional services rendered are charged to the patient's parents or legal guardian. Necessary forms will be completed to help expedite insurance carrier payments. The parents or legal guardian, are responsible for all fees regardless of insurance coverage. I, as the legal guardian of the above named patient, agree to be responsible for the patient's account.

_____ _____

Patient's Signature or Legal Guardian Relationship

_____

Date

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OFFICE POLICY AGREEMENT FORM

Date:_____

Patient Name:_____

Person responsible for account:_____

METHOD OF PAYMENT

*Payment in full at each appointment
*Insurance co-payment in full at each appointment
*Credit/Debit Card

I understand that I am responsible for all fees incurred for my dental treatment. Most insurance plans are payment assistance plans; they are not designed to cover the entire cost of treatment. It is the responsibility of the guardian or self to know their insurance benefits and coverage's. ***Co-payments and treatment not covered by your insurance is your responsibility and due at the time of appointment.***

NO SHOW FEE

There is a $50.00 fee for patient's that do not show up for their reserved appointment or cancel without giving a 24-hour notice or more.

AUTHORIZATION

I hereby authorize payment directly to Healthy Smiles Pediatric Dentistry, P.C. otherwise payable to me. I understand that I am responsible for all costs of dental treatment and I understand that my dental insurance carrier may pay less than the actual bill for services. I hereby authorize Healthy Smiles Pediatric Dentistry, P.C. to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information listed is correct to the best of my knowledge.

SIGNATURE OF RESPONSIBLE PARTY

X_____ Date_____

*** Any account which has an outstanding balance over 60 days and no payment arrangements will incur a charge of 1.5% per month (18% per year) and will be responsible for any additional charges that may occur if the account is turned over to a collection agency. ***

Healthy Smiles Pediatric Dentistry
Anne T. Nghiem, DMD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign This Acknowledgement*

PARENT OR LEGAL GUARDING FOR_____have
Received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

_____
For Office Use Only
_____

We attempted to obtain written acknowledgement of the receipt to our notice of Privacy Practices, but acknowledgement could not be obtained:

_____ Individual refused to sign

_____Communications barriers prohibited obtaining the acknowledgement

_____An emergency situation prevented us from obtaining acknowledgement

_____Other (Please Specify)

_____
_____
_____