ORAL HEALTH FORM

RANDALL W. HOLLENBERG, D.D.S., P.A.
Pediatric Dentistry

We welcome your child into our practice and we will try to make his/her dental experiences very pleasant. Please complete this form thoroughly because this information is of great value in helping us to better understand and care for your child.

Child's Name ____________________

What is your child called (nickname) ____________________ Date of Birth ____________ Current Weight ________

Name and age of brothers and sisters ____________________

Child's physician or pediatrician ____________________

Physician's phone ____________________ Family dentist ____________________

Dental Insurance: Yes__________ No__________ Name of insurance company ____________________

Who may we thank for referring you to our office? ____________________

Address if known ____________________

Name and kind of child's favorite pet, toy, hobby, or sport activity ____________________

What is your chief complaint, if any, about your child's mouth or teeth? ____________________

____

Purpose of this visit ____________________

HEALTH HISTORY

HAS CHILD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING:

_______	Anemia	_______	Chicken Pox	_______	Hepatitis	_______	Mental Retardation	_______	Tuberculosis
_______	Asthma	_______	Convulsions	_______	HIV+/ AIDS	_______	Mononucleosis	_______	Vision Disorders
_______	Bladder Disease	_______	Diabetes	_______	Kidney Disorders	_______	Mumps	_______	Other
_______	Blood Disorders	_______	Epilepsy	_______	Liver Disease	_______	Rheumatic Fever		
_______	Bleeding Disorders	_______	Hearing Disorders	_______	Lung Disease	_______	Sinus Problems		
_______	Cancer	_______	Heart Disorders	_______	Measles	_______	Thyroid Disorders		
_______	Cerebral Palsy	_______	Heart Murmur						

	Yes	**No**
1. Is your child in good health?	_______	_______
2. Is your child under the care of a physician now? for illness or injury?	_______	_______
3. Has your child had an unexplain weight loss in the last 12 months?	_______	_______
4. Is your child taking any medicines or drugs?	_______	_______
If so, what? ____________________		
5. Does your child have any swollen glands or lymph nodes?	_______	_______
6. Is there excessive bleeding when cut?	_______	_______
7. Has your child ever been hospitalized?	_______	_______
8. Has your child ever had surgery?	_______	_______
9. Is there any allergy or unfavorable reaction to antibiotics (e.g. penicillin), local anesthetics, or other drugs? If so, please specify ____________________	**Yes**	**No**
10. Are there other allergies: food, pollen, animals, dust, other?	_______	_______

11. Current immunizations:

______	2 mo. (DPT, TOPV, HIB)	______	6 mo. (DPT, TOPV, HIB)	______	18 mo. (DPT, TOPV)
______	4 mo. (DPT, TOPV, HIB)	______	12 mo. (MMR)	______	5 yr. (DPT, TOPV, MMR booster)

12. Is there any other information I should be aware of that is not mentioned above? _______ _______

Please describe ____________________

____

____

DENTAL AND FAMILY HISTORY

	Yes	**No**
1. Has your child any history of nail biting, thumbsucking, fingersucking, mouth breathing, teeth grinding, or did he use a pacifier past age 1 1/2 years? (Underline condition)	______	______
Is this a currently active habit?	______	______
2. Does your child have or has he/she had frequent ear and throat infections or tubes in ears?	______	______
3. Has your child any history of hearing loss or speech problems?	______	______
(Underline and explain) ____________________		
4. Has child ever had pain/tenderness in their jawjoint (TMJ)?	______	______
5. Has mother or father had a lot of tooth decay?	______	______

– Continued on Reverse Side –

Child's Name ____________________ Date ____________

		Yes	No
6.	In your family is there any history of malocclusions, bad bites, missing or extra teeth? (Underline and explain) ____________	___	___
7.	Has your child had a toothache recently?	___	___
8.	Is your child in pain now?	___	___
9.	Do you think there is anything wrong with his/her teeth, such as a chipped tooth, decayed tooth, gum boil, etc? Explain ____________	___	___
10.	Has your child had previous dental treatment? When and Where? ____________	___	___
11.	Do mother and father and child live together? If no, please explain.	___	___
12.	Is your child adopted?	___	___

13. If you previously completed this form for another child please give that child's name. ____________

Other remarks. ____________

____

____

PREVENTIVE ASSESSMENT*

Tooth cleaning

Frequency. Times per day _______ When? ____________

Type of toothbrush ____________

Dental floss ☐ Yes ☐ No

Disclosing tablets ☐ Yes ☐ No

Who is responsible for tooth cleaning? ☐ Parent ☐ Child ☐ Both

Have you received instruction in tooth cleaning? ☐ Yes ☐ No

Reviewed by: ____________ Date ________

Dr. Initials: ____________ Date ________

Fluoride inventory

Water fluoridation ☐ Yes ☐ No ☐ Unsure

Fluoride supplements ☐ Yes ☐ No What kind ________

Fluoride rinse ☐ Yes ☐ No Water analysis _____

Fluoride toothpaste ☐ Yes ☐ No

Thank you for your careful answering of this form. Please also provide the following information:

Father or Stepfather ____________ (FULL NAME)

Texas Driver's Lic. # ____________ D.O.B. ________

Soc. Sec. # ____________ Cell ____________

Mother or Stepmother ____________ (FULL NAME)

Texas Driver's Lic. # ____________ D.O.B. ________

Soc. Sec. # ____________ Cell ____________

Home Address ____________ (STREET CITY STATE ZIP CODE) Phone ____________

Own ☐ Rent ☐ How long? ________ Best E-mail Address: ____________

Mailing Address if different from home address ____________ (STREET CITY STATE ZIP CODE)

Father Employed By ____________ (IF SELF, STATE BUSINESS NAME) How Long? ________

Occupation ____________

Business Address ____________ (STREET CITY STATE ZIP CODE) Phone ____________

Mother Employed By ____________ (IF SELF, STATE BUSINESS NAME) How Long? ________

Occupation ____________

Business Address ____________ (STREET CITY STATE ZIP CODE) Phone ____________

In case of emergency – Name of nearest relative or friend ____________ Phone ____________

Name of other relative or friend ____________ Phone ____________

Because your child is a minor, it is necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment is performed.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment, regardless of what insurance may pay.

I also understand a finance charge of 1.5% (18% APR) is charged on any unpaid balance remaining sixty days after the time of service. This finance charge also applies to accounts for which insurance has been filed.

Date ____________ Signed ____________

Notice of Privacy Practices

Randall W. Hollenberg, D.D.S.
Pediatric Dentistry
830 South Mason Road, Suite B-2
Katy, Texas 77450

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purpose: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosure will be made only with your written authorization. You mat revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alter native means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or policies and procedures of our office. We will not retaliate against you for filling a complaint.

For more information about HIPAA or to file a complaint: The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201, Toll Free: 1-877-696-6775.

I,______________________________________, have reviewed this office's Notice of Privacy Practices and have been offered a copy.

____

Patient's Name   Parent/Guardian Signature   Date