TODDLER HEALTH HISTORY

RANDALL W. HOLLENBERG, D.D.S.
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 thisinformation 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 ______________ 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 Palsey	______	Heart Murmur						

	Yes	No
1. Is your child in good health?	______	______
2. Is your child under the care of a physician now?	______	______
3. Is your child taking any medicines or drugs?	______	______
If so, what? ______________________		
4. Is there excessive bleeding when cut?	______	______
5. Has your child ever been hospitalized?	______	______
6. Has your child ever had surgery?	______	______
7. Is there any allergy or unfavorable reaction to antibiotics (e.g. penicillin), local anesthetics, or other drugs? If so, please specify. ______________________		
8. Are there other allergies: food, pollen, animals, dust, other?	______	______

9. 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)

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

12. If you have previously completed this form for another child please give that child's name ______________________

Other Remarks ______________________________

____

— Continued on Reverse Side —

Date ______________

Child's Name ____

FEEDING HISTORY

☐ Breast Fed
- ☐ Totally. How Long? __________mo.
- ☐ Schedule frequency________________________
- ☐ On-demand feeding
- ☐ Bedtime
- ☐ Supplemental bottle. When began? _________mo.
- ☐ Weaned _____________mo.

☐ Bottle Fed
- ☐ Ready-to-feed formula
- ☐ Formula reconstituted with water
- Average time of each feeding ______________________
- Bedtime bottle ☐ Yes ☐ No Contents ______________
- Bottle used as pacificer ☐ Yes ☐ No Contents ______________
- Age bottle discontinued ______________________

MATERNAL-PRENATAL HISTORY

	Yes	No
1. Did you have a normal pregnancy?	☐	☐
2 . Did you experience any difficulties or complications during pregnancy?	☐	☐

If so, explain. ____

3 . Did you experience any of the following during pregnancy?
- ☐ Severe morning sickness
- ☐ Taking medications, antibiotics, etc.
- ☐ Physical trauma or injury
- ☐ Illness (other than colds or flu)
- ☐ Other ____

Comments ____

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

Fluoride inventory
- Water fluoridation ☐ Yes ☐ No ☐ Unsure
- Fluoride supplements ☐ Yes ☐ No What kind _______
- Fluoride rinse ☐ Yes ☐ No Water analysis ____
- Fluoride toothpaste ☐ Yes ☐ No

Reviewed by: ____________________ Date ____________

Dr. Initials: ____________________ Date ____________

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

Father or Stepfather ______________________________ (FULL NAME)

Mother or Stepmother ______________________________ (FULL NAME)

Texas Driver's Lic. # ____________________ D.O.B. __________ Texas Driver's Lic. # ____________________ D.O.B. __________

Soc. Sec. # __________________ Cell __________________ 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 ______________________________

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Notice of Privacy Practices

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