

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 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 _____ 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)
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 _____

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 pacifier** **Yes** **No** **Contents** _____
- Age bottle discontinued** _____

MATERNAL-PRENATAL HISTORY

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 1. Did you have a normal pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did you experience any difficulties or complications during pregnancy? | <input type="checkbox"/> | <input type="checkbox"/> |

If so, explain. _____

3. Did you experience any of the following during pregnancy?

- | | |
|---|---|
| <input type="checkbox"/> Severe morning sickness | <input type="checkbox"/> Taking medications, antibiotics, etc. |
| <input type="checkbox"/> Physical trauma or injury | <input type="checkbox"/> Illness (other than colds or flu) |
| <input type="checkbox"/> 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 _____ <small style="text-align: center;">FULL NAME</small>	Mother or Stepmother _____ <small style="text-align: center;">FULL NAME</small>
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Texas Driver's Lic. # _____ D.O.B. _____	Texas Driver's Lic. # _____ D.O.B. _____
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Soc. Sec. # _____ Cell _____	Soc. Sec. # _____ Cell _____
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Home Address _____ <small style="text-align: center;">STREET CITY STATE ZIP CODE</small>	Phone _____
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Own Rent How long? _____ Best E-mail Address: _____

Mailing Address if different from home address _____ <small style="text-align: center;">STREET CITY STATE ZIP CODE</small>	
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Father Employed By _____ <small style="text-align: center;">IF SELF, STATE BUSINESS NAME</small>	How Long? _____
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Occupation _____

Business Address _____ <small style="text-align: center;">STREET CITY STATE ZIP CODE</small>	Phone _____
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Mother Employed By _____ <small style="text-align: center;">IF SELF, STATE BUSINESS NAME</small>	How Long? _____
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Occupation _____

Business Address _____ <small style="text-align: center;">STREET CITY STATE ZIP CODE</small>	Phone _____
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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

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 may 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 alternative 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 filing 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.