ORAL HEALTH FORM

KATY KIDS DENTIST

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 ______________________ Date of Birth ______________ Current Weight ________ Male or Female

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 ______________________

How were you referred to our office?

Internet: Google Yahoo Insurance Website Facebook Yelp Other:______________________

Patient: If yes, please let us know who to thank:______________________

Doctor/Dentist: If yes, please let us know who to thank: ______________________

Daycare/School:______________________ Insurance: ______________________

Street Sign Katy Magazine Yellow Pages

Other: Please Explain:______________________

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

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______________________
10. Are there other allergies: food, pollen, animals, dust, other? .... _______ _______
11. Current immunizations: _____ 2 mo. (DTap, HBV, IPV, HIB, PCV13, Rota) _____ 4 mo. (DTap, HBV, IPV, HIB, PCV13, Rota)

    _____ 6 mo. (DTap, HBV, IPV, HIB, PCV13, Rota) _____ 12 mo. (MMR, Varivax, HepA, PCV13) _____ 15 mo. (HIB, Dtap, PPD)

    _____ 18 mo. (HepA) _____ 4 yr. (Dtap, IPV, MMR, Varicella) _____ 11 yr. (Tdap, MCV4) _____ 16 yr. (MCV4#2)
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?.. ______ ______
4. Has child ever had pain/tenderness in their jawjoint (TMJ)? .... ______ ______
5. Has mother or father had a lot of tooth decay?.. ______ ______
6. In your family is there any history of malocclusions, bad bites, missing or extra teeth? .... ______ ______

   (Underline and explain)______________________

– Continued on Reverse Side –

	Yes	No
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? ______________________

Dental floss? ☐ 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

Fluoride rinse ☐ Yes ☐ No

Fluoride toothpaste ☐ Yes ☐ No

DIETARY HABITS

Frequent Snacking? ☐ Yes ☐ No

Frequent juice/sweet drinks? ☐ Yes ☐ No

Sippy Cup? ☐ Yes ☐ No

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

FATHER'S INFORMATION

Name:______________________________

Father Stepfather Guardian Birthdate: ______ / ______ / ______

Address:______________________________

____
City State Zip

Employer: ______________________ Occupation: _______________

Work #: (_______) ______________________________

Home #: (_______) ______________________________

Cell #: (_______) ______________________________

SSN: ___________________________ DL #: ____________________

Email Address: ______________________________

MOTHER'S INFORMATION

Name:______________________________

Mother Stepmother Guardian Birthdate: ______ / ______ / ______

Address:______________________________

____
City State Zip

Employer: ______________________ Occupation: _______________

Work #: (_______) ______________________________

Home #: (_______) ______________________________

Cell #: (_______) ______________________________

SSN: ___________________________ DL #: ____________________

Email Address: ______________________________

In case of emergency – Name of nearest relative or friend__________________________ Relationship _______________ Phone ________________

Name of other relative or friend ______________________________ Relationship _______________ 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 ______________________________

Katy Kids Dentist
Pediatric Dentistry

Financial Arrangements and Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payments for services are due at the time the services are rendered unless payment arrangements have been previously approved. We accept cash, checks, MasterCard, Visa, Discover, American Express and Care Credit.

There is a $25.00 service charge for returned checks. Balances 60 days and older will be subject to additional collection fees and interest charges of 1.5% per month. The 60 days starts from the first day the charges were acquired whether or not insurance has been filed.
We will gladly discuss your child's proposed treatment and answer any questions relating to your insurance.

Our office is happy to cooperate with families who are covered by dental insurance. We only ask that you read your policy to be sure that you are fully aware of any limitations of the benefits provided. Unfortunately, we are unable to accept assignment of benefits for emergency or orthodontic visits.

The fees we charge for services rendered to those who are insured are our usual and customary fees charged to all patients for similar services. Your insurance policy may base it's allowances on a fixed fee schedule which may or may not coincide with our usual fees. You should be aware that different insurance companies vary greatly in the type of coverage available. Also some companies pay claims promptly, and others delay payments many months.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility. Delay or failure of an insurance company to pay all or part of a claim is a matter that should be dealt with by the patient directly with the insurance company. In the event full payment for services rendered has not been received from the insurance company within 60 days from the time of service, we will expect you to pay the outstanding balance at that time. A finance charge of 1.5% per month (APR 18%) will be charged on any amount unpaid after 60 days from the time of service.

There is no charge for appointments rescheduled with 24 hours notice. It is not our intent or wish to charge this fee. We ask that our patients telephone us within 24 hours, should they foresee a problem with keeping an appointment, so we may offer this time to a patient waiting for an appointment.

______________________	______________________________	______________
Patients Name	Parent/ Guardian Signature	Date

Katy Kids Dentisty
Pediatric Dentistry
830 S. Mason Rd #B-2 Katy, Texas 77450
Phone 281-392-3333 Fax 281-392-4083

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Katy Kids Dentist's Notice of Privacy Practices, which has an effective date of 09/23/2013, and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

______________________________________ ____________________
Signature of Patient or Patient's Representative Date

____
Print Name

____
Relationship to Patient (If not signed by the Patient)