TODDLER HEALTH HISTORY

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 Yelp Facebook Insurance Website 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 Welcome Wagon

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. 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. (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)

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?	_____	_____
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 _____		

	Yes	No
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 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
- ☐ Weaned _____ mo.

☐ Bottle Fed

- Bedtime bottle ☐ Yes ☐ No Contents_____
- Bottle used as pacifier ☐ Yes ☐ No Contents _____
- Age bottle discontinued _____

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)