Pediatric Medical History

Child's legal name: _____ Nickname: _____ Date of birth: _____/_____/_____

Birth sex: ❑ M ❑ F Current gender identity: _____ Pronouns: _____ Race/Ethnicity: _____ Height: ____cm Weight: ____kg

Name/age and relationship of others living in the household: _____

_____

Primary physician: _____ Address/phone: _____ Last visit: _____

Medical specialists: _____ Address/phone: _____ Last visit: _____

Is your child being treated by a physician at this time? Reason _____ ❑ YES ❑ NO

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? ❑ YES ❑ NO

List name, dose, frequency & date started: _____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ❑ YES ❑ NO

List date & describe: _____

Has your child ever had a reaction to or problem with an anesthetic? Describe _____ ❑ YES ❑ NO

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____ ❑ YES ❑ NO

Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ ❑ YES ❑ NO

Is your child up to date on immunizations against childhood diseases? ❑ YES ❑ NO

Is your child immunized against human papilloma virus (HPV)? ❑ YES ❑ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions ❑ YES ❑ NO

Problems with physical growth or development ❑ YES ❑ NO

Sinusitis, chronic adenoid/tonsil infections ❑ YES ❑ NO

Sleep apnea/snoring, mouth breathing, or excessive gagging ❑ YES ❑ NO

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease ❑ YES ❑ NO

Irregular heart beat or high blood pressure ❑ YES ❑ NO

Asthma, reactive airway disease, wheezing, or breathing problems ❑ YES ❑ NO

Cystic fibrosis ❑ YES ❑ NO

Frequent colds or coughs, or pneumonia ❑ YES ❑ NO

Frequent exposure to tobacco smoke ❑ YES ❑ NO

Jaundice, hepatitis, or liver problems ❑ YES ❑ NO

Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ❑ YES ❑ NO

Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ❑ YES ❑ NO

Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder ❑ YES ❑ NO

Bladder or kidney problems ❑ YES ❑ NO

Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis ❑ YES ❑ NO

Rash/hives, eczema or skin problems ❑ YES ❑ NO

Impaired vision, visual processing, hearing, or speech ❑ YES ❑ NO

Developmental disorders, learning problems/delays, or intellectual disability ❑ YES ❑ NO

Cerebral palsy, brain injury, epilepsy, or convulsions/seizures ❑ YES ❑ NO

Autism/autism spectrum disorder ❑ YES ❑ NO

Recurrent or frequent headaches/migraines, fainting, or dizziness ❑ YES ❑ NO

Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) ❑ YES ❑ NO

Attention deficit/hyperactivity disorder (ADD/ADHD) ❑ YES ❑ NO

Behavioral, emotional, communication, or psychiatric problems/treatment ❑ YES ❑ NO

Abuse (physical, psychological, emotional, or sexual) or neglect ❑ YES ❑ NO

Diabetes, hyperglycemia, or hypoglycemia ❑ YES ❑ NO

Precocious puberty or hormonal problems ❑ YES ❑ NO

Thyroid or pituitary problems ❑ YES ❑ NO

Anemia, sickle cell disease/trait, or blood disorder ❑ YES ❑ NO

Hemophilia, bruising easily, or excessive bleeding ❑ YES ❑ NO

Transfusions or receiving blood products ❑ YES ❑ NO

Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant ❑ YES ❑ NO

Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS ❑ YES ❑ NO

PROVIDE DETAILS HERE: _____

_____

_____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? ❑ YES ❑ NO

If YES, describe _____

_____

What is your primary concern about your child's oral health? _____

How would you describe:

your child's oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
your oral health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
the oral health of your other children? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Not applicable

Is there a family history of cavities? ❑ YES ❑ NO If yes, indicate all that apply: ❑ Mother ❑ Father ❑ Brother ❑ Sister

Does your child have a history of any of the following? For each YES response, please describe:

Inherited dental characteristics ❑ YES ❑ NO _____
Mouth sores or fever blisters ❑ YES ❑ NO _____
Bad breath ❑ YES ❑ NO _____
Bleeding gums ❑ YES ❑ NO _____
Cavities/decayed teeth ❑ YES ❑ NO _____
Toothache ❑ YES ❑ NO _____
Injury to teeth, mouth or jaws ❑ YES ❑ NO _____
Clinching/grinding his/her teeth ❑ YES ❑ NO _____
Jaw joint problems (popping, etc.) ❑ YES ❑ NO _____
Excessive gagging ❑ YES ❑ NO _____
Sucking habit after one year of age ❑ YES ❑ NO If yes, which: ❑ Finger ❑ Thumb ❑ Pacifier ❑ Other ❑ For how long? _____

How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? ❑ YES ❑ NO

How often does your child floss his/her teeth? ❑ Never ❑ Occasionally ❑ Daily Does someone help your child floss? ❑ YES ❑ NO

What type of toothbrush does your child use? ❑ Hard ❑ Medium ❑ Soft ❑ Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? ❑ City/community supply ❑ Private well ❑ Bottled water

Do you use a water filter at home? ❑ YES ❑ NO If YES, type of filtering system: _____

Please check all sources of fluoride your child receives:

❑ Drinking water ❑ Toothpaste ❑ Over-the-counter rinse ❑ Prescription rinse/gel ❑ Prescription drops/tablets/vitamins
❑ Fluoride treatment in the dental office ❑ Fluoride varnish by pediatrician/other practitioner ❑ Other: _____

Does your child regularly eat 3 meals each day? ❑ YES ❑ NO
Is your child on a special or restricted diet? ❑ YES ❑ NO If YES, describe: _____
Is your child a 'picky eater'? ❑ YES ❑ NO If YES, describe: _____
Does your child have a diet high in sugars or starches? ❑ YES ❑ NO If YES, describe: _____
Do you have any concerns regarding your child's weight? ❑ YES ❑ NO If YES, describe: _____

How frequently does your child have the following?

Candy or other sweets ❑ Rarely ❑ 1-2 times/day ❑ 3 or more times/day Product _____
Chewing gum ❑ Rarely ❑ 1-2 times/day ❑ 3 or more times/day Type _____
Snacks between meals ❑ Rarely ❑ 1-2 times/day ❑ 3 or more times/day Usual snack _____
Soft drinks* ❑ Rarely ❑ 1-2 times/day ❑ 3 or more times/day Product _____

(* such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities? ❑ YES ❑ NO If YES, list: _____
Does your child wear a mouthguard during these activities? ❑ YES ❑ NO If YES, type: _____
Has your child been examined or treated by another dentist? ❑ YES ❑ NO
If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____
Were x-rays taken of the teeth or jaws? ❑ YES ❑ NO Date of most recent dental x-rays: _____
Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ❑ YES ❑ NO If YES, when? _____
Has your child ever had a difficult dental appointment? ❑ YES ❑ NO If YES, describe: _____

How do you expect your child will respond to dental treatment? ❑ Very well ❑ Fairly well ❑ Somewhat poorly ❑ Very poorly

Is there anything else we should know before treating your child? ❑ YES ❑ NO

If yes, describe: _____

Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history

Please continue to supplemental questions on the following page….

How do you think your child has reacted to past medical procedures?

- Very well
- Moderately well
- Moderately poorly
- Very poorly

How would you rate your own anxiety (fear, nervousness) at this moment?

- High
- Moderately High
- Moderately Low
- Low

Does your child think there is anything wrong with his or her teeth, such as a chipped tooth, decayed tooth, or gum boil?

- Yes
- No

How do you expect your child to react in the dental chair?

- Very well
- Moderately well
- Moderately poor
- Very poorly

Do you consider your child to be (check one)

- Advanced in learning
- Progressing normally
- A slow learner
    - If so, does your child receive special services at school? Yes No

Patient Registration

Last Name: _____ First Name: _____ Preferred Name: _____

Date: _____ Birthdate: _____ Sex: _____

School Attending: _____

Parent/Guardian #1: _____ DOB: _____

Home Phone: _____ Cell Phone: _____ Ok to Text? Yes ☐ No ☐

Street: _____ City: _____ State: _____ Zip: _____

Parent/Guardian #2: _____ DOB _____

Home Phone: _____ Cell Phone _____ Ok to Text? Yes ☐ No ☐

Street: _____ City: _____ State: _____ Zip: _____

Email Address: _____

How did you hear about us? _____

Primary Insurance Information

Dental Insurance: _____

Insurance Policy Number: _____ Group Number: _____

Dental Insurance Phone Number: _____ Employer Name: _____

Secondary Insurance Information

Dental Insurance: _____

Insurance Policy Number: _____ Group Number: _____

Dental Insurance Phone Number: _____ Employer Name: _____

Parent/Legal Guardian Name: _____

Signature:_____

Date: _____

Authorization To Treat A Minor

Today's Date: _____

Patient/Childs Name: _____

Birthdate: _____

I, as the Parent/Guardian of _____, am legally able to make all medical/dental decisions for said child. I understand that by signing this form, all responsibility for consenting to proposed and performed treatment is my decision, and I do not legally need to consult anyone else in order to authorize treatment of my child.

I am authorizing the following person(s) to consent to preventive dental treatment in the event that I cannot attend a dental appointment, which is limited to examinations, radiographs, cleanings, fluoride treatment (including other remineralization procedures), sealant application, and emergency situations.

As the Parent/Guardian, I understand I must sign the treatment plan for any treatment recommendations. I also understand that a Parent/Guardian must be present during any dental procedure beyond preventive, and must remain in the office in its entirety.

Name of Authorized Person (to bring child to dental appointment):_____

Relationship:_____

Name of Authorized Person (to bring child to dental appointment):_____

Relationship:_____

Parent/Legal Guardian Name:_____

Signature:_____

Exam, Fluoride, X-Rays And Cleaning Consent

Today's Date: _____

Patient Name: _____

Patient Date of Birth: _____

I consent to the dental provider and team to examine my child.

I consent for my child to receive a dental cleaning.

I consent for topical fluoride being placed on my child's teeth, following a dental cleaning. The team will do their best to inform me if my insurance covers this treatment at each appointment, or the cost to me if my insurance does not cover it. I understand I may be responsible for the fee if my insurance does not cover the fluoride application.

I consent to digital dental X-rays being taken on my child as needed for proper diagnosis.
The office uses ALARA (as low as reasonably achievable) principle for taking dental radiographs, however, I understand that additional X-rays may occasionally be necessary to obtain a proper diagnosis of a dental condition and/or to evaluate growth and development.

I have read and understand each consent on this form. I understand that these consents will remain in effect while my child is a dental patient at Advanced Pediatric Dentistry, unless I request changes.

Parent/Legal Guardian Name: _____

Signature: _____

Financial Agreement

Today's Date: _____

Patient Name: _____

Patient's Date of Birth: _____

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at this time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

If you do not have insurance, we expect payment in full for all treatment at the time of service, unless other arrangements have been previously made. We accept cash, checks, VISA and MasterCard.

REGARDING INSURANCE

If you have insurance, we can assist you in submitting your claim. Your insurance claim will ONLY be completed and submitted if we are provided with all pertinent insurance company information. It is your responsibility to verify that your policy is in effect at the time your services are performed. Otherwise, you are responsible for payment at the time of service.

Insurance is an agreement between you and your insurance company. We will inform you if we are participating with your insurance plan and will handle your claim according to our agreement with the insurance company. We file insurance claims as a courtesy to you, our patient. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, coverage charges, secondary insurances, "usual and customary" charges, etc., other than to supply necessary factual information. Deductibles and/or co-payments are required to be paid by you at the time of service. You are responsible for the prompt payment of your account. If payment is not received from your insurance company by us within 90 days, the balance of the account becomes your responsibility. I hereby authorize and agree as follows:

I authorize the use of this form on all my insurance submissions.
I authorize release of information to all my insurance companies.
I understand I am responsible for my account.
I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.
I authorize payment directly to my doctor.
I permit a copy of this authorization to be used in place of the original.
I understand benefit information given to me by my doctor or their staff is not a guarantee of payment
I understand that payment of my account must be received within 90 days of date of service, regardless of my insurance.

I have read the above Financial Policy and understand that I am financially responsible for all charges, whether or not they are paid by my insurance. I understand that if my account is not paid within 90 days, it will be turned over to the Credit Bureau for collection and a 30% collection fee will be added.

Parent/Legal Guardian Name: _____

Signature: _____

Missed Appointment Policy

Today's Date: _____

Patient Name: _____

Patient's Date of Birth: _____

	Initial
Your appointment time is reserved especially for you. We ask a courtesy to our team and other patients that you keep your appointments as scheduled. If you do need to change an appointment, we require a 48 hour advance notice.	_____
We will do our best to contact you via phone to confirm your child's appointment within 48 hours of your scheduled time. It is your responsibility to provide us with accurate contact information, so that we may reach out to you for your reminder. We will attempt to leave a voicemail message if we are unable to reach you directly. Ultimately, however, it remains your responsibility to show up for your child's appointment.	_____
Patients who arrive 10 minutes or later for their appointment may be asked to wait or reschedule for another time. Our appointments are scheduled on the hour or half hour, unless we have made a special exception. We make every effort to stay on schedule so that we can respect your time as well.	_____
If you miss an appointment after 3PM Monday through Friday without advanced notice, you will not be allowed to schedule another after school appointment. If you miss a Saturday appointment without advanced notice, you will not be able to receive another Saturday appointment.	_____
If your child is scheduled for a treatment appointment and results in a no-show or late show up for the appointment, you will be required to make a 20% deposit on scheduled treatment in order to reschedule, which will be non-refundable if the appointment is missed.	_____
I have read and understand the office missed appointments policy.	_____

Parent/Legal Guardian Name: _____

Signature: _____

Notice of Privacy Policies

Today's Date: _____

SECTION A: PATIENT GIVING CONSENT

Last Name: _____ First Name: _____ Birthdate: _____

Address: _____
_____
_____

Telephone: _____

Email: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosures of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Advanced Pediatric Dentistry
Attn: Privacy Officer
Telephone: 717-697-5437
Address: 220 Cumberland Parkway Suite 6, Mechanicsburg, PA 17055

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you, if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Parent/Legal Guardian Name: _____

Signature: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

Photograph and Video Release

Today's Date: _____

Patient's Name: _____

Location:

Advanced Pediatric Dentistry
220 Cumberland Parkway Suite 6
Mechanicsburg, PA 17055

I hereby give permission to Advanced Pediatric Dentistry (APD) to use the photographs and/or video of me and or my minor child(ren) taken for promoting, publicizing and advertising purposes. I understand that these photographs or videos may appear in publication or on the APD website and/or social media outlets (Instagram, Facebook). I release APD from all claims for financial compensation now for said photos and in the future.

I certify that I am over 18 years of age. I am the parent or guardian of the minor child(ren) named below (if applicable)

I have read and understand each consent on this form. I understand that these consents will remain in effect while my child is a dental patient at APD, unless I request changes.

Printed Name of Parent/Legal Guardian: _____

Phone Number: _____

Email: _____

Name(s) of Minor Children:

_____

_____

_____

_____

Signature: _____

☐ I DO NOT CONSENT TO HAVING MY CHILD PHOTOGRAPHED OR VIDEO TAPED.

Bill Of Rights And Responsibilities

Today's Date: _____

Patient Name: _____

Patient Date of Birth: _____

BILL OF RIGHTS:
These rights can be exercised on the patient's behalf by a parent or legal guardian if the patient is a minor, lacks decision-making capacity, or is legally incompetent. The patient has the right to:

- A dental home that provides comprehensive, considerate, and respectful care.
- Have oral health diagnoses made by a dentist.
- A choice of oral health care provider. The parent has a right to designate a pediatric dentist as a primary oral health care provider for the child.
- Participate fully in all the decisions related to his/her care.
- Receive accurate, relevant, current and easily-understood information concerning diagnosis, treatment and prognosis. The patient is entitled to the opportunity to discuss and request information related to the specific procedures and/or treatments, the risks involved, and the medically reasonable alternatives and their accompanying risks and benefits. Life threatening emergency care could be an exception
- Make decisions about the plan of care prior to and during the course of treatment, to refuse a recommended treatment or plan of care to the extent permitted by law, and to be informed of the health consequences of this action. In case of such refusal, the patient is entitled to other appropriate care and services that the pediatric dentist offers or to transfer to another dentist.
- Consent to or decline to participate in proposed research studies affecting care and treatment of requiring direct patient involvement and to have those studies explained fully prior to consent. A patient who declines to participate in research is entitled to the most effective care that the pediatric dentist can otherwise provide.
- Expect reasonable continuity of care.
- Emergency care for acute dental trauma and odontogenic infections, as needed.
- Know the identity, education and training of the providers involved in his/her care, as well as when those involved are students, residents, or other trainees.
- Know the immediate and long-term financial implications of treatment choices, insofar as they are known. The patient has the right to be informed of the charges for services and available payment methods.
- Be informed of the provider's policies and practices that relate to patient care, treatment and responsibilities. The patient has the right to be informed of available resources for resolving disputes, grievances, and conflicts, such as ethics committees, patient representatives, or other mechanisms available in an organization.
- Every consideration of privacy. Case discussion, consultation, examinations and treatment should be conducted so as to protect each patient's privacy.
- Expect that all communications and records pertaining to his/her care will be treated as confidential, except in cases such as suspected abuse and public health hazards when reporting is permitted or required by law. The patient has the right to expect that the provider will emphasize the confidentiality of information released to other parties entitled to review this information.
- Review the records pertaining to his/her medical care and to have the information explained or interpreted as necessary, except when restricted by law. The patient has the right to request amendments to his/her record.
- Ask and be informed of the existence of business relationships among institutions, other health care providers, or payers that may influence the patient's treatment and care.

BILL OF RESPONSIBILITIES:
These responsibilities can be exercised on the patient's behalf by a parent or legal guardian if the patient is a minor, lacks decision-making capacity, or is legally incompetent.

- The patient is responsible for providing, to the best of his/her knowledge, accurate and complete information about current/past medical conditions, current/past allergies to any substance, current/past illnesses, hospitalizations, medications, and other matters related to his/her health status.
- The patient must take responsibility for requesting additional information or clarification about his/her health status or treatment when he/she does not fully understand information and instructions.
- The patient is responsible for his/her actions if he/she refuses treatment or does not follow the instructions of the provider. It is the patient's responsibility to inform dentists and other caregivers of anticipated problems in following prescribed treatments, including follow-up treatment instructions.
- The patient has a responsibility to keep appointments and when unable to do so, to notify the dental office as soon as possible.
- The patient is responsible for being considerate of the rights of other patients and health care workers and for not interfering with the general functioning of the facility.
- The patient is responsible for providing accurate insurance information and for accepting the financial obligations associated with the services rendered.

I have had full opportunity to read and consider the contents of the BILL OF RIGHTS and BILL OF RESPONSIBILITIES. I understand that I am giving my permission for your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Parent/Legal Guardian Name: _____

Signature: _____