Victoria Kids Dentistry

This record is confidential and for use only in this office.
The following information and history are necessary for the adequate treatment and understanding of your child.
Thank you for completing it in full.

SOCIAL HISTORY

Patient's Full Name_____ **Preferred Name**_____ **Age**_____

Sex _____ Date of Birth_____

☐ Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Defiant
☐ Suspicious ☐ Moody ☐ High Strung ☐ Regular Kid ☐ Friendly ☐ Cooperative

Name & type of child's pet _____ Favorite Interest_____ Favorite Sport_____

How do you expect your child to react to his/her visit today? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Not sure

Child lives with: ☐ Both Parents ☐ Mother ☐ Stepmother ☐ Father ☐ Stepfather ☐ Grandparent ☐ Other

Patient's Address_____ Zip_____ Home Phone_____

Father(s) Full Name_____ DL#_____ Social Security #_____

Where Employed_____ Wk Phone_____ Mobile Phone_____

Mother(s) Full Name_____ DL#_____ Social Security #_____

Where Employed_____ Wk Phone_____ Mobile Phone_____

Whom may we thank for referring you to our office? Doctor_____ Parent_____ Patient_____

Has this office rendered treatment to any other family members? Names:_____

Reason for bringing child to dentist_____

Insurance (Dental) _____ Date of Birth of Insured: (not child)_____

Email_____

MEDICAL HISTORY

Condition of the child's general health_____ Weight_____

How long since your child's last physical examination?_____ How long since his/her last tetanus shot?_____

Child's physician _____

Address_____ Phone_____

☐ Yes ☐ No Are your child's immunizations up to date? If no, explain _____

☐ Yes ☐ No Does your child have physical or mental disabilities? If yes, explain_____

☐ Yes ☐ No Has your child ever been hospitalized? Date_____
Reason_____ Doctor_____ Where_____

☐ Yes ☐ No Has your child had any operations or surgeries? Date_____
Reason_____ Doctor_____ Where_____

☐ Yes ☐ No Has your child received medical treatment within the last six months? If yes, explain _____

☐ Yes ☐ No Has your child ever had hearing, sight, speech, or learning problems? If yes, explain_____

☐ Yes ☐ No Is your child currently receiving speech therapy? If yes, by whom?_____

☐ Yes ☐ No Has your child ever received injuries to the head, jaw, mouth, or teeth? If yes, explain_____

☐ Yes ☐ No Is your child allergic to any medicine or food? If yes, what?_____

☐ Yes ☐ No Is your child taking any medicine now? If yes, what?_____

ILLNESS

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no.

☐ This child has never been diagnosed as having any of the below conditions.

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS (Immunosuppresive Disorder)	☐	☐	Eye Problems	☐	☐	Polio
☐	☐	Anemia	☐	☐	Excessive Bleeding Problem	☐	☐	Pregnant
☐	☐	Allergy	☐	☐	Fainting	☐	☐	Psychiatric Disorder
☐	☐	Arthritis	☐	☐	Hearing Loss	☐	☐	Scarlet Fever
☐	☐	Asthma	☐	☐	Heart Disease	☐	☐	Scoliosis
☐	☐	Autism	☐	☐	Hemophilia	☐	☐	Sickle Cell Anemia
☐	☐	Brain Injury	☐	☐	Hepatitis - Type_____	☐	☐	Sinus Problems
☐	☐	Bronchitis	☐	☐	Jaundice	☐	☐	Snoring at Night
☐	☐	Cancer	☐	☐	Leukemia	☐	☐	Sore Throats - Frequent
☐	☐	Cerebral Palsy	☐	☐	Measles	☐	☐	Spina Bifida
☐	☐	Chicken Pox	☐	☐	Mental Retardation	☐	☐	Syndrome_____
☐	☐	Cleft Lip/Palate	☐	☐	Mumps	☐	☐	Tetanus
☐	☐	Convulsions/Seizures	☐	☐	Mouth Breathing	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Nutritional Deficiency	☐	☐	Whooping Cough
☐	☐	Diptheria	☐	☐	Orthopedic Problems	☐	☐	Other_____
☐	☐	Epilepsy	☐	☐	Pneumonia	☐	☐	_____

DENTAL HISTORY

☐ Yes ☐ No Is this your child's first trip to the dentist? If no, name of previous dentist _____
Approximate date of last visit _____

☐ Yes ☐ No Has your child experienced any unfavorable reactions from previous dental or medical care? If yes, explain _____

☐ Yes ☐ No Has your child had a toothache recently?

☐ Yes ☐ No Has your child received any trauma to his/her teeth?

☐ Yes ☐ No Does your child have a history of mouthbreathing, thumbsucking, fingersucking, pacifier dependency, lip/nail biting or other habits? (If yes, Circle)

How was your child fed as an infant? ☐ Breast ☐ Bottle

When did you stop breast or bottle feeding? Age_____

☐ Yes ☐ No Is your child taking any vitamins or fluoride?

What toothpaste does your child use? _____

What is your water source? ☐ Private Well ☐ City Water Name of City: _____

What source water do you drink? ☐ Tapped ☐ Bottled

How often are your child's teeth brushed per day? _____ By Whom? _____

☐ Yes ☐ No Does your child have a dental condition about which you are especially concerned? If yes, explain _____

☐ Yes ☐ No Does your child consume large amounts of sugar? If yes, source _____

☐ Yes ☐ No Does your child gag easily?

☐ Yes ☐ No Is there anything else about your child that you think I should know in order to better plan his/her dental treatment? _____

INSURANCE PATIENTS PLEASE SIGN:

I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.
I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME..

X _____ _____

SIGNED (INSURED PATIENT OR PARENT IF MINOR) DATE

CONSENT

I acknowledge that the above mentioned information is correct, and I authorize Victoria Kids Dentistry PLLC and staff to provide dental and related medical/surgical treatment as deemed necessary utilizing proper and acceptable methods to complete same, including diagnostic radiographs and photographs. Because statements and billing have become so expensive and in an effort to keep my dental costs down, I understand that payment is expected as services are rendered.

Parent or Legal Guardian Date

_____ _____

VICTORIA KIDS DENTISTRY

Office Financial Policy

In order to provide the quality dental care that you desire for your child and minimize administrative cost, it is necessary to have an understanding between our families and the office regarding payment for dental services. We will discuss treatment and fees with you. The office accepts the following forms of payment: Cash, Check (with valid Drivers License), Visa, MasterCard, Discover, and American Express.

Families without dental insurance (Cash Pay) Full payment is due at each visit per services rendered.

Families with dental insurance You will need to bring your Insurance I.D card with you to the appointment. We must have policy number, phone number, and information regarding where to file claims. Without this information we will be unable to file the claim. You will be asked to pay for the visit. You assign benefits to the office and we will file insurance. The payment must come directly to our office. **We will require you to pay the portion insurance does not pay at the time of each visit. If benefits are not paid in 60 days, the balance is due by the family. **Our office policy is that the parent or guardian bringing the child is the financially responsible party. We will provide receipts.****

Our office sets out a specific period of time for dental procedures. **You are subject to a missed appointment fee if appointments are missed without proper notification (24 hours) to our office.**

A $30 charge will be assessed on all returned checks to our office

I, the undersigned, have read and fully understand the contents of this policy

Signature_____ **Date**_____

CONSENT FOR DENTAL TREATMENT

State Law requires us to obtain your consent for contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.

1. I hereby authorize and direct Victoria Kids Dentistry and staff to perform upon my child (or legal ward) dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays), or diagnostic aids. All x-rays are the property of this office.
2. In general terms the dental procedure(s) or operation may include:
   A. Cleaning of teeth and the application of topical fluoride
   B. Application of sealants to the grooves of the teeth
   C. Treatment of diseased or injured teeth with dental restorations(fillings, pulpotomies, crowns).
   D. Removal (extraction) of one or more teeth.
   E. Treatment of diseased or injured oral tissues.
   F. Administration of Nitrous Oxide gas.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated. There can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I further authorize the doctor to perform other dental services that in his/her judgment are advisable for my child or legal ward, with the exception of _____.

Although their occurrence is extremely rare, some risks have been reported to be associated with dental or oral surgery procedures. State law requires us to mention the possible risk of numbness, infection, swelling, discoloration, nausea, vomiting, hematoma, allergic reactions, brain damage, quadriplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures.

I hereby state that I have read and understand this consent, and that all questions have been answered in a satisfactory manner, and I understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Signature of Parent/Guardian_____ **Date**_____

VICTORIA KIDS DENTISTRY

101 Professional Park Drive
Victoria, Tx 77904
Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

* Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
* Obtain payment from third-party payers.
* Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____ Date_____

Office Use Only

I attempted to obtain the Patient/Guardian's signature in acknowledgement on this Notice *of Privacy Practices* Acknowledgement, but was unable to do so as documented below:

Date:_____ Reason:_____
Initials:_____