PEDIATRIC DENTISTRY OF COLLEYVILLE

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Colleyville, TX 76034
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Email: Info@PDofC.com
www.PediatricDentistryofColleyville.com

Patient Information

Patient name:____Date:________________
Last First MI
☐ Male ☐ Female

Social Security #:_____________________________Birthdate:___________________Age:_____

Preferred Name:________________________Pets/Hobbies:________________________________

Brothers/Sisters (name):____

School:____

Home address:____

____Home Phone:___________________________

Email address:____

Would you like to receive an email to confirm future appointments? ☐ Yes ☐ No

Please circle the phone number that is the best to confirm appointments.

Father's Information

☐ Guardian ☐ Step

Name:________________________________

DOB: ________________________________

Driver License #: _____________________

Employer:____________________________

Home Phone #:________________________

Work Phone #:_________________________

Cell Phone #:__________________________

Mother's Information

☐ Guardian ☐ Step

Name:________________________________

DOB: ________________________________

Driver License #: _____________________

Employer:____________________________

Home Phone #:________________________

Work Phone #:_________________________

Cell Phone #:__________________________

In case of an emergency, please call:

Name:________________________________ Phone #:______________________________

Referral Information

Whom may we thank for referring you to our practice?

☐ Another patient ______________________

☐ Dental Office _________________________

☐ Internet

☐ Ft Worth Child Magazine

☐ School ______________________________

☐ Pediatrician __________________________

☐ Website

☐ Suburban Parent Magazine

☐ Other ____

Medical History

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

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
ADD/ADHD	☐	☐	Diabetes	☐	☐	Mental disabilities	☐	☐
AIDS/ HIV+	☐	☐	Down Syndrome	☐	☐	Physical disabilities	☐	☐
Allergies/Sinus	☐	☐	Eye Problems	☐	☐	Pregnant	☐	☐
Asthma	☐	☐	Hearing Loss	☐	☐	Psychiatric problems	☐	☐
Autism	☐	☐	Heart murmur	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Heart problems	☐	☐	Sensory Disorder	☐	☐
Cerebral Palsy	☐	☐	Hemophilia	☐	☐	Shunts	☐	☐
Convulsions/Seizures	☐	☐	Hepatitis/Type______	☐	☐	Tuberculosis	☐	☐
Spina Bifida	☐	☐						

Question	Yes	No
1. Was your child full term?	☐	☐
2. Did your child have any difficulty after birth or any serious illnesses the first year of life?	☐	☐
3. Is your child being treated by a physician at this time? If yes, why?____	☐	☐
4. Is your child taking any medication/vitamins at this time? If yes, what?____	☐	☐
5. Has your child ever been hospitalized? If yes, explain.____	☐	☐
6. Is your child allergic to anything? (medicine/food) If yes, what?____	☐	☐

7. Does your child have problems in: ☐ concentrating ☐ learning ☐ cooperating ☐ understanding

8. Name of child's physician:_______________________________Physician's phone #:____________________

Date of last visit:____________________________ Immunizations up to date? ☐ Yes ☐ No

9. How would you rate your child's attitude toward medical / dental visits?
☐ positive ☐ anxious ☐ definitely negative

10. Is there anything else we should know about your child?____

____

Staff comments: ____

____

Dental History

1. Is this your child's first dental visit? ☐ Yes ☐ No
   If no, give date of last examination:____________________ Dentist name:____________________

2. Has your child ever had any of the following? Please check.
   ☐ abscesses ☐ toothaches ☐ cold sores ☐ ulcers
   ☐ bad breath ☐ injury to front teeth ☐ grinding

3. Does your child have any habits or a history of a habit?
   Pacifier ☐ Yes ☐ No ☐ Age discontinued ____________________

   Finger / thumb ☐ Yes ☐ No ☐ Age discontinued ____________________

4. Is there a history of dental decay or missing teeth in the family?
   ☐ Yes ☐ No If yes, Explain:____________________

5. Are your child's teeth brushed once or more a day by an adult? ☐ Yes ☐ No ; Floss? ☐ Yes ☐ No

6. What dental concerns do you have about your child?____________________

   ____

7. If your child is under the age of 6, when did first baby tooth erupt?____________________

Diet History

1. Did or Do you breast feed your child? ☐Yes ☐ No
   What age did you discontinue breastfeeding?____________________

2. Did or Do you bottle feed your child? ☐ Yes ☐ No
   What age did you discontinue bottle-feeding?____________________

3. What foods does your child like for a snack?____________________

4. What does your child drink on a daily basis? ____________________

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Ta and his dental staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I give Dr. Ta and his staff permission to send records or x-rays to another facility/doctor in case of emergency. This consent shall remain in full force and effect until canceled by either party.

____________________ ____________________ ____________________

Signature of parent or guardian Relationship to patient Date

Pediatric Dentistry of Colleyville

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), 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 been informed by your office of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the rights to review such *Notice of Privacy Practices* prior to signing this consent. 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 below to obtain a current copy of the *Notice of Privacy 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.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

____
Patient Name

____
Relationship to Patient

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify):

____

____

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Office Policies

Appointments: Please inform our office in advance if you are unable to keep your appointment. A non-refundable fee of $50.00 will be charged to your account if the appointment is cancelled within less than 48 hours. This fee will not be charged to your insurance company. You will be responsible for this charge.

Insurance: Insurance information is required at least 48 hours prior to the appointment time. Changes in insurance require a notice of the change at least 48 hours prior to the appointment. Failure to provide current insurance information may result in an out of pocket payment for the appointment.

____________________________ _____________________ __________________________ _______________
Signature of parent or guardian Relationship to patient Patient's Name Date

Photo Consent

I, ________________________________, parent or official guardian of _______________________ hereby grants permission to Pediatric Dentistry of Colleyville representatives, to take and use: photographs and/or digital images of my child for use as follows: printed publications or materials, electronic publications, or web sites. I agree that my child's name (excluding last name) and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me.

____________________________ ______________________ ______________
Signature of parent or guardian Relationship to patient Date