# IMPORTANT

Complete the attached patient health history form for each new patient and return it to our office in the enclosed envelope before the appointment.

If you have insurance that we participate with it is important that we receive your completed form before the visit so we may verify your insurance benefits.

Dentistry for Children of West Essex, LLC

Date: _____

Child's Name _____ Nickname _____

Child's Birthdate _____ Age _____ Sex: Male Female

*Please circle*

Address _____

Home Phone _____ Primary Cell Phone _____ Email Address _____

Have any of your other children ever been seen in this office? Yes No

Names and Ages of Brothers and Sisters _____

Tell us something about your child (favorite hobbies, pets, tv shows, etc). _____

_____

WHO SHALL WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Please circle how you plan on handling your child's visit? Cash Check Visa MasterCard Discover CareCredit

---

Father's/Parent's Name _____ Address _____

Father's/Parent's Employer _____

Father's/Parent's Employer's Address _____

Work Phone Number _____ Cell Phone Number _____ Social Security # _____

Name & Address of Dental Insurance Company _____

ID # _____ Group Number _____ Date of Birth _____

---

Mother's/Parent's Name _____ Address _____

Mother's/Parent's Employer _____

Mother's/Parent's Employer's Address _____

Work Phone Number _____ Cell Phone Number _____ Social Security # _____

Name & Address of Dental Insurance Company _____

ID # _____ Group Number _____ Date of Birth _____

**MEDICAL HISTORY**

Date of last medical exam: _____ Name of Physician: _____

Physician's Address and Phone #: _____

***If you answer yes to any of these questions please give an explanation in the space provided at the end of this form.***

| | |
|---|---|
| Any learning, behavioral, excessive nervousness, or communication problems? | No ( ) Yes ( ) |
| Were there any complications during pregnancy or was the child premature at birth? | No ( ) Yes ( ) |
| Any problems with physical growth? | No ( ) Yes ( ) |
| Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness? | No ( ) Yes ( ) |
| Any sensory disorders? (Seeing, Hearing) | No ( ) Yes ( ) |
| Any history of congenital heart disease, or heart damage from rheumatic fever? | No ( ) Yes ( ) |
| Has any heart surgery been done or recommended? | No ( ) Yes ( ) |
| Any history of chest pains or high blood pressure? | No ( ) Yes ( ) |
| Any history of a heart murmur? | No ( ) Yes ( ) |
| Has your child ever had a blood transfusion or blood products transfusion? | No ( ) Yes ( ) |
| Any history of sickle cell disease? | No ( ) Yes ( ) |
| Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts? | No ( ) Yes ( ) |
| Has your child ever tested positive for HIV? | No ( ) Yes ( ) |
| Has your child been diagnosed as being a hemophiliac? | No ( ) Yes ( ) |
| Any history of pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty in breathing? If yes, describe: _____. | No ( ) Yes ( ) |
| Any history of stomach, intestinal or liver problems? | No ( ) Yes ( ) |
| Any history of hepatitis or jaundice? | No ( ) Yes ( ) |
| Any history of eating disorders, such as anorexia nervosa or bulimia? | No ( ) Yes ( ) |
| Any history of unintentional weight loss? | No ( ) Yes ( ) |
| Any history of urinary tract infections, bladder or kidney problems? | No ( ) Yes ( ) |
| Is the patient pregnant or possibly pregnant? | No ( ) Yes ( ) |
| Any history of diabetes? | No ( ) Yes ( ) |
| Any history of thyroid disorders or other glandular disorders? | No ( ) Yes ( ) |
| Any history of skin problems? | No ( ) Yes ( ) |
| Any history of cold sores (herpes) or canker sores (apathies)? | No ( ) Yes ( ) |
| Any limitations of use of arms or legs? | No ( ) Yes ( ) |
| Any arthritis or other joint problems? | No ( ) Yes ( ) |
| Any problems with muscle weakness or muscular dystrophy? | No ( ) Yes ( ) |

Is your child allergic to any medications? If yes, please list. No ( ) Yes ( )

_____

Any hay fever, hives, skin rashes caused by allergies? No ( ) Yes ( )
Any other allergies?_____ No ( ) Yes ( )

Is your child currently taking medication (prescription or non prescription)? No ( ) Yes ( )

| Medication | Dosage | Times Per Day |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Has your child ever received radiation therapy (x-ray treatments) or is it planned? No ( ) Yes ( )
Has your child ever received chemotherapy or is it planned? No ( ) Yes ( )

Has your child been hospitalized? No ( ) Yes ( )

| | | |
|---|---|---|
| Hospital | (1) _____ | (2) _____ |
| Date | _____ | _____ |
| Reason | _____ | _____ |

## DENTAL HISTORY

Does your child have a toothache or any other immediate dental problem? No ( ) Yes ( )
Has your child ever had a toothache? No ( ) Yes ( )
Has your child ever had an injury to the mouth? No ( ) Yes ( )
Is this your child's first dental visit? No ( ) Yes ( )
If no: Date: _____ Dentist: _____
Reason: _____
Has your child ever had an unfavorable dental experience? No ( ) Yes ( )
Was your child nourished by nursing beyond the age of one? No ( ) Yes ( )
If yes, check: Breast_____ Nursing Bottle_____ Both_____ and to what age? _____

Does your child fail to eat a well-balanced diet? No ( ) Yes ( )
If yes, what foods or food groups are not adequate?_____
Does your child have any oral habits? If yes, please check: No ( ) Yes ( )
Thumb(s)_____ Finger(s)_____ Pacifier_____ Other_____
Does your child have difficulty opening his or her mouth, or does the child's jaw sometimes lock or stick in certain positions? No ( ) Yes ( )
Does your child have popping or clicking noises or pain during chewing or yawning? No ( ) Yes ( )
Does your child have frequent headaches or pain in or about the ears, eyes, or cheeks? No ( ) Yes ( )

## DENTAL DISEASE INFORMATION

How often does your child brush? _____ time(s) per _____
Does your child use dental floss? No ( ) Yes ( )
Does someone assist your child with brushing and cleaning their teeth? No ( ) Yes ( )
Does your child use fluoride toothpaste? No ( ) Yes ( )
Has your child ever had a fluoride treatment? No ( ) Yes ( )
Has your child ever taken a fluoride supplement or vitamins with fluoride? No ( ) Yes ( )
Does your child use a fluoride rinse? No ( ) Yes ( )

**Please note any special needs or comments we should know in order to better care for your child.**

I understand this information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

**X** Parent/Guardian Signature: _____ Date: _____

CONSENT: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, mediation and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for the above mentioned patient is mine, due and payable at the time services are rendered unless financial arrangements have been make in advance. I further understand that 1.5% finance charge (18% annually) will be added to my balance over 90 days. In the event of default I promise to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

MISSED APPOINTMENTS: Scheduled appointments are a good faith agreement between the patient and this practice. In consideration of our patients' needs and out of respect for the doctors' time there is a charge for missed appointments.

**X** Parent/Guardian Signature: _____ Date: _____

**THE PARENT WHO BRINGS THE PATIENT IN FOR TREATMENT IS RESPONSIBLE FOR ALL FEES INCURRED AT THE TIME SERVICES ARE RENDERED.**

---

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
**You May Refuse to Sign the Acknowledgement**

I, _____, have received a copy of this office's Notice of Privacy Practices.

**X** 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* _____ *Communications barriers prohibited obtaining the acknowledgement*

_____ *An emergency situation prevented us from obtaining acknowledgement* _____ *Other (Please Specify):*_____

We, here at Dentistry for Children of West Essex, LLC, are dedicated to providing our patients with superior dental care. However, there may be times when the recommended treatment may not always be covered by your dental insurance, even if we participate with the plan.

Each insurance plan has different benefits and if you would like to know your exact coinsurance/responsibility please request a predetermination. A predetermination may take up to four weeks to be processed and might delay treatment, but we will be happy to provide you with this service.
We will always do our very best to give you the service you expect and the care you deserve. Always feel free to ask questions about your child's recommended treatment because an informed patient is a satisfied patient.

I have read and understand the above statement **X**_____ _____
(Parent/Guardian signature) (date)

**White Filling Policy**

Our office recommends white fillings for our patients. The benefits of composite restorations for primary teeth are: 1) Wear the same rate as natural teeth, 2) Release fluoride to help prevent recurrent decay, 3) Less sound tooth structure removed, 4) Better color match to tooth, and 5) Easily repaired as opposed to being completely removed.

The advantages of composites over amalgams for permanent molars are: 1) Natural tooth color material, 2) Only decayed tooth structure is removed saving more healthy tooth structure, 3) They are bonded to the natural tooth preventing leakage at the edges, 4) They can be easily repaired while silver fillings must be completely replaced, and 5) Sealants can be bonded over the composite to protect the rest of the chewing surface.

Some insurance plans do not cover composite restorations and change the coverage to an alternative benefit and will utilize the amalgam benefits. You will be responsible for the difference between the composite and amalgam restoration.

Composite restorations are superior over the old amalgam type restorations and the restorations of choice for your child.

I have read and understand the above statement **X**_____ _____
(Parent/Guardian signature) (date)

**Primary Care Physician Report**

We will be communicating with the patient's primary physician/referring dentist regarding their dental health.

I understand a letter will be sent to my child's doctor **X**_____ _____
(Parent/Guardian signature) (date)