



**8. MEDICAL HISTORY**

Child's Name: \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

Does your child take any medications?  Y  N  
If yes, please list medications and include dosage  
\_\_\_\_\_

Are immunizations up-to-date?  Y  N

Has your child been treated in an emergency room?  Y  N  
If yes, Please explain  
\_\_\_\_\_

Has your child been hospitalized, or had surgery?  Y  N  
If yes, Please explain  
\_\_\_\_\_

Has your child ever had any of the following conditions?

<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur	<input type="checkbox"/> Y <input type="checkbox"/> N Hypoglycemia
<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Heart Valves	<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Cleft Lip/Palate
<input type="checkbox"/> Y <input type="checkbox"/> N Scarlet Fever	<input type="checkbox"/> Y <input type="checkbox"/> N Birth Defects
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Tumors	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Jaw Problems TMJ/TMD	<input type="checkbox"/> Y <input type="checkbox"/> N Thyroid Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Hearing/Visual Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Sickel Cell
<input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N Seizures/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones/Joints
<input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis	<input type="checkbox"/> Y <input type="checkbox"/> N Liver/Kidney Problem
<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Problems	<input type="checkbox"/> Y <input type="checkbox"/> N HIV/AIDS
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma/Difficulty Breathing	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis TB
<input type="checkbox"/> Y <input type="checkbox"/> N Seasonal Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N Hyper Active/ADD
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion	<input type="checkbox"/> Y <input type="checkbox"/> N Autism
<input type="checkbox"/> Y <input type="checkbox"/> N Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N Behavioral Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N Mental/Physical Delay
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Pregnancy

Allergic to:

<input type="checkbox"/> Y <input type="checkbox"/> N Latex	<input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline
<input type="checkbox"/> Y <input type="checkbox"/> N Penicillin/Amoxicillin	<input type="checkbox"/> Y <input type="checkbox"/> N Food Allergies
<input type="checkbox"/> Y <input type="checkbox"/> N Aspirin	Other: _____

**9. DENTAL HISTORY**

Previous Dentist: \_\_\_\_\_

Date of last exam: \_\_\_\_\_

Date of last x-rays: \_\_\_\_\_

Reason for today's visit:  
 Exam  Consultation  Emergency

How often does your child floss? \_\_\_\_\_

How often does your child brush? \_\_\_\_\_

Who brushes your child's teeth? \_\_\_\_\_

Is your child bottle fed or breast fed? \_\_\_\_\_

Does your child take fluoride supplements?  Y  N

Is your child's water fluoridated?  Y  N

Please check any of the following that apply to your child:

Bad Breath

Bleeding Gums

Clicking or Popping Jaw

Food Collection Between Teeth

Grinding Teeth

Loose teeth or Broken Fillings

Injury to Face or Mouth

Sensitivity to Cold/Heat

Sensitivity to Sweets

Sores or Growth in Mouth

Mouth Breathing

Thumb/Finger Sucking

Pacifier Sucking

Lip Biting

Nail Biting

**10. PLEASE READ AND SIGN BELOW**

*I affirm that the information I have given on this form is correct to the best of my knowledge and is my responsibility to inform this office of any changes in my child's medical status.*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Your Signature** **Date**

\_\_\_\_\_  
*Dr. Signature* *Date*



## General Consent for Treatment

Our office specializes in the dental health of children. We strongly believe in the establishment of a dental home for your child for preventive dental care in a safe and comfortable environment. In order to provide the best dental care, we are required to obtain your consent before performing any dental services for your child. Please read this form carefully and we encourage you to ask us about anything that you do not understand, we will be happy to explain it to you.

I hereby authorize and direct Sweetpea Smiles, with the support of licensed dentists and/or dental auxiliaries to perform upon my child the following dental treatment or oral surgery procedures including the necessary or advisable local anesthesia, radiographs (x-rays), photographs or diagnostic aids.

In general terms, the dental procedures may include one, or a number of, the following:

1. Cleaning of the teeth and application of fluoride
2. Application of sealants to the grooves of teeth
3. Treatment of diseased or injured teeth with dental restorations
4. Stainless steel crowns for children. These are necessary in cases where simple fillings would not be the best long term restoration or in cases where there are large cavities
5. Extraction (removal) of one or more teeth that cannot be saved
6. Treatment of diseased or injured oral tissues (hard and/or soft)
7. Treatment of malposed (crooked) teeth and/or developmental abnormalities
8. Behavior guidance through the use of a mouth prop, tell-show-do method and/or voice control
9. Protective stabilization including holding my child or the use of a papoose board
10. Use of sedation medications and/or nitrous oxide to control apprehension

The treatment has been explained to me and I understand that none of the above procedures will be performed without discussing the necessity with me and obtaining my consent to proceed. Alternative methods of treatment, if any have been explained to me, along with their advantages, disadvantages and risks. I am advised that good results are expected; however, the possibility and nature of complication cannot be accurately anticipated. Therefore, no guarantee, expressed or implied, can be given to me regarding this treatment. I further understand and authorize the doctor to perform any necessary treatment that in his/her judgment will be in the best interest of my child's health, once treatment has been initiated.

Although their occurrence is rare and unpredictable, some risks are known to be associated with dental or oral surgery procedures, medication and/or anesthetics. We are required to disclose the known risks of numbness, infection, aspiration (swallowing), swelling, bleeding, discoloration, nausea, vomiting, allergic reaction, the loss of function of organs, or scarring. I understand and accept that complications may require medical assistance, hospitalization and in very rare cases death.

I hereby state that I have read and fully understand this consent. I have been given an opportunity to ask questions regarding this consent and proposed treatment. I also understand that this consent will remain in effect until such time that I choose to terminate. Such termination of consent must be in writing.

Patient Name: \_\_\_\_\_

Signature of Parent/ Guardian: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



## General Office Policies

A parent/legal guardian must accompany each child to all dental visits. Only a parent/legal guardian can consent for treatment or fill out your child's medical history.

### Parent Participation

Parents are welcome to accompany their child for exam and cleaning appointments. Parents are required to remain in the waiting room while their child is receiving treatment. At subsequent visits we encourage that you allow our staff to accompany your child through the dental experience. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome apprehension. There are instances when a parent's presence is needed during treatment, this will be evaluated on an individual patient basis.

### Scheduled Appointments

We attempt to schedule appointments at your convenience and whenever time is available. Preschool children and school children requiring extensive dental treatment are best seen in the morning when they are fresher and well rested because they tend to be more cooperative, which allows for a more comfortable experience for the child. In order to allow the best possible care for our patients, we reserve a specific time for your child and make every effort to see him/her as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your child's appointment, it is required that a 48-hour notification is made to our office. If this requirement is not met, a possible charge of \$25.00 will be added to your account.

### Payment Responsibility

All payments are due at time of service. However, most insurance plan benefits can be used for treatment in our office. Please check with your insurance plan administrator for more details. During your visit we will collect what we estimate your insurance will not pay. Actual insurance reimbursement may vary from our estimate. You are responsible for the full balance on your account. In the case of divorce or separation the parent that brings the child in for the visit is responsible for payment at the time of the visit. Please see our insurance specialist or business manager with any questions.

### X-Ray Records

By law, x-rays taken here are the property of this office. If for some reason you may need a copy of your x-ray records, a \$25 processing fee will be required prior to delivery of the x-rays.

Thank you for choosing Sweetpea Smiles as your child's Oral Healthcare Provider. 😊

*I have read and understand these policies and hereby authorize my insurance company to send payments directly to Sweetpea Smiles and understand that I am responsible for all remaining balances.*

Patient's Name \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_



## Notice of Privacy Form

### Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of Sweetpea Smiles' HIPAA Notice of Privacy Practices.

\_\_\_\_\_  
*Print Patient's Name*

\_\_\_\_\_  
*Signature of Patient*

\_\_\_\_\_  
*Date*

**OR**

\_\_\_\_\_  
*Signature of Personal Representative*

Parent     Guardian     Power of Attorney     Other \_\_\_\_\_

***Please Note: It is your right to refuse to sign this acknowledgement.***

*I tried to obtain written acknowledgement by the individual noted above of receipt of our Notice of Privacy Practices, but it could not be obtained because:*

- An emergency prevented us from obtaining acknowledgement*
- A communication barrier prevented us from obtaining acknowledgement*
- The individual was unwilling to sign*
- Other:* \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
*Staff Member Signature*

\_\_\_\_\_  
*Date*