Child Health and Dental History Form

Patient Name _____ Nickname _____ Date of Birth _____ M__ F__ __/__/__/__

How did you hear about our office? _____

Parent or Guardian Name _____ S.S. # __/__/__ Relationship to Patient _____

Physical Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Parent or Guardian Phone during the day _____ Phone during evening _____

Parent or Guardian email address _____

Have you (parent or guardian) or the patient had any of the following problems:

Active Tuberculosis: Y__ N__ Persistent cough longer than 3 weeks: Y__ N__ Cough producing blood: Y__N__

If you answer YES to ANY of the above questions, please stop and return this form to the desk

Condition	Yes	No	Don't know	Condition	Yes	No	Don't know	Condition	Yes	No	Don't know
Anemia	0	0	0	Hearing	0	0	0	Epilepsy	0	0	0
Arthritis	0	0	0	Heart	0	0	0	Fainting	0	0	0
Asthma	0	0	0	Measles	0	0	0	Growth Problems	0	0	0
Bladder	0	0	0	HIV/AIDS	0	0	0	Allergy to Bananas	0	0	0
Bleeding Disorders	0	0	0	Immunizations	0	0	0	Seizures	0	0	0
Ear Aches	0	0	0	Kidney	0	0	0	Rheumatic Fever	0	0	0
Cancer	0	0	0	Latex Allergy	0	0	0	Thyroid	0	0	0
Cerebral Palsy	0	0	0	Liver	0	0	0	Tobacco	0	0	0
Chicken Pox	0	0	0	Sickle Cell	0	0	0	Venereal Disease	0	0	0
Chronic Sinusitis	0	0	0	Mononucleosis	0	0	0	Bones/Joints	0	0	0
Diabetes	0	0	0	Mumps	0	0	0	Allergy to Kiwi	0	0	0
Hepatitis	0	0	0	Pregnancy (teens)	0	0	0	Tuberculosis	0	0	0

Insurance Information

S.S. # of policyholder _____ Relationship to Patient _____ Patient ID _____

Name of Employer _____ Work phone _____

Insurance Company _____ Group # _____

Address _____ City _____ Zip _____

Insurance Company phone number _____

Please Answer the Following Questions:

	Y	N
1. Is the child taking any prescribed and/or over the counter medicine, vitamins, or supplements? _____ If so , please list_____	0	0
2. Is the child allergic to any medications, i.e. Penicillin, antibiotics, or any other drugs?_____ Please list_____	0	0
3. Is the child allergic to anything else, such as certain foods? Please Explain_____	0	0
4. How would you describe the child's eating habits?_____		
5. Has the child ever had a serious illness? Please explain_____	0	0
6. Has the child ever been hospitalized? If so when and why_____	0	0
7. Does the child have or ever had a serious illness? If yes, when?_____	0	0
8. Has the child ever received general anesthetic?_____	0	0
9. Does the child have any inherited problems?_____	0	0
10. Does the child have any speech difficulties?_____	0	0
11. Has the child ever had a blood transfusion?_____	0	0
12. Is the child physically, mentally, or emotionally impaired?_____	0	0
13. Does the child experience excessive bleeding when cut?_____	0	0
14, Is the child currently being treated for any Illness? _____	0	0
15. Is the child's first visit to the dentist? If not, when was the last visit? Date_____	0	0
16. Has the child ever had any dental x-rays? If so, when and where_____	0	0
17. Has the child ever had any difficulty with dental treatment in the past?_____	0	0
18. Has the child ever suffered any injuries to the mouth, head, or teeth?_____	0	0
19. Has the child had any problems with losing primary teeth or the eruption of adult teeth?_____	0	0
20. Has the child had orthodontic treatment?_____	0	0
21. What type of water does your child drink? 0 City Water 0 Well Water 0 Bottled Water 0 Filtered Water		
22. Does the child take fluoride supplements?_____	0	0
23. Does the child use fluoride toothpaste ?_____	0	0
24. How many times does the child brush per day?_____When does the child brush?_____		
25. Does the child suck his/her thumb, fingers, or pacifier?_____	0	0
26. At what age did the child stop bottle feeding? Age_____ Breast Feeding_____		
27. Does the child participate in recreational activities?_____	0	0

Please list the child's medicines here:

_____

Note: Both Doctor and Patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any action they take because of errors or omissions that I may have made in the completion of this for _____.

Patient Name)

Parent/Guardian Signature _____Date:_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to the child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and./or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services . I understand that dental treatment is a partnership and that appointments are reserved exclusively for me. In the event of a failed appointment where there is less than 24 hours notice there may be a fee charged. Further, I understand that accounts overdue by 60 days are subject to an interest fee of 18% APR and/or late fees. I will not hold my dentist, or any other member of his staff, responsible for any action they take because of errors or omissions that I may have made in the completion of this for the above named child.

X_____Date:_____

Parent/Guardian Child Signature

Robert A. Foster, Jr., DMD PC

1230 Johnson Ferry Road, Suite C-10
Marietta, GA 30068
(770) 971-5119

Recommended Standard of Dental Care for Children

- Professional cleanings and complete examinations by a dentist are generally recommended every six- (6) months. Children who are particularly cavity prone may need to have more frequent visits.
- Radiographs for detection of hidden decay (cavity detecting x-rays) are recommended on at least a six- (6) month interval.
- A full mouth x-ray that shows facial bones and the formation of permanent teeth is recommended every 3 years unless otherwise indicated by unusual circumstances.
- Professional application of fluoride is generally recommended every six- (6) months. Fluoride strengthens teeth in its battle with plaque, the precursor to decay. A child with a high decay rate may require additional treatments.
- Application of sealant material to all chewing surfaces of permanent molars and premolars is recommended as soon as the teeth are completely present and unobstructed by soft tissue. SEALANTS MAY BE RECOMMENDED ON PRIMARY TEETH if a child is particularly prone to cavities at a very early stage in life.
- Give your child fluoridated water. TYPICALLY, BOTTLED WATER DOES NOT CONTAIN FLUORIDE. Read the label. You may want to consider a water purifier connected to your tap. The purifier will not remove fluoride.
- Avoid rewarding your child with sticky, chewy, sugary foods without making sure they are able to brush their teeth right after the snack. Instead offer a snack from the vegetable or fruit groups.
- Acquiring good dental hygiene habits at home will require parental supervision. The skills of brushing and flossing are hard at first. Your child will need your guidance. Be available and patient with them. And, best of all; let them learn by your good example.

Financial Options

(Please read, sign and return....Thank you)

Our commitment is to provide quality dental care to the entire family through exceptional service and the utilization of advanced technology

Methods of payment

Cash, Check, or Credit card (MasterCard, Visa, American Express, and Discover)
Dental Insurance (described below)
Care Credit –a credit card specifically designed for healthcare use (application available)or **www.carecredit.com**
Citi Health Card-Apply in the office or online at **www.healthcard.citicards.com** Both of these plans offer flexible financing. No interest plans may be available ***but with specific requirements in order to receive such arrangement.***

Dental Insurance:

We are pleased you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company. ***We consider the patient responsible for the payment of the account.*** If your insurance company agrees to make payment directly to the doctor, we will accept insurance assignment.

We ask that your estimated co-payment and deductible be paid at the time of service.
Not all services are a covered benefit in all contracts. ***Some insurance companies arbitrarily select certain services they will cover. Many plans have exclusions and limitations, which will affect your out-of-pocket expense.*** Whenever possible, we will submit an estimate to your insurance company for an outline of benefits for which you may be entitled.

Billing:

We estimate your co-payment portion based on information given to us by your insurance carrier. Payment of your portion is expected at the time you are in our office for dental care. ***However, sometimes there is a need to send a statement for the portion insurance has not paid, and this is due upon receipt.***

• **Beginning 01-01-2011, accounts may also be assessed a $5.00 per month rebilling fee.** Please keep us informed if you are having difficulty meeting your financial obligation.
For patients requiring extensive treatment, we offer ***short-term payment plans***. For patients who desire a longer period of time to make payment, an application through the above named health card institutions can be made.

Related Information:

Returned checks are subject to additional collection fees. In the event that the account is not paid and we refer the account to collection, you will be responsible for all fees incurred for collection of the bill (i.e., attorney fees, court costs, and collection agency fees).

Your appointment has been reserved exclusively for you. Any change in your appointment affects many patients***. 24 hours notice is needed to avoid a charge***.

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred from services rendered. I further authorize the payment of dental benefits otherwise payable to me directly to Robert A. Foster, Jr., DMD PC.

Name ***(Please print)*** _____ ***(parent/guardian if patient is under 21)***

Signature_____***Date***_____