Shining Smiles Pediatric Dentistry

Dr. Rod Stern

HEALTH HISTORY FORM **PATIENT ACCOUNT NUMBER _____**

1. Tell Us About Your Child

Child's Name _____

Goes By: _____ ☐ Male ☐ Female

Name & Ages of Siblings _____

_____

Child's Birthday _____/_____/_____ Child's Age _____

School _____ Grade _____

SS# _____

Reason For Visit _____

_____

_____

☐ Mother's Information

Name _____

Mother Stepmother Guardian Birthdate _____/_____/_____

Marital Status: _____

Employer: _____

Work # _____ Ext. _____

Home/Cellular Phone #'s _____/_____

SS#_____

Home Address_____

_____

☐ Father's Information

Name _____

Father Stepfather Guardian Birthdate _____/_____/_____

Marital Status: _____

Employer: _____

Work # _____Ext. _____

Home/Cellular Phone #'s _____/_____

SS#_____

Home Address_____

_____

4. We confirm appointments by text and email.

Cell phone number to **text** to _____

Email address _____

☐ Who May We Thank For Referring You To Our Office?

_____

6. With Whom Does Your Child Reside?

_____

☐ Primary Dental Insurance

Insurance Company Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

Group # _____ID# _____

Policy Owners Name _____

Relationship to Patient _____

Policy Owner's Birthday ____/____/____ SS# _____

Policy Owner's Employer _____

☐ Secondary Dental Insurance

Insurance Company Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone #_____

Group # _____ ID# _____

Policy Owners Name _____

Relationship to Patient _____

Policy Owner's Birthday ____/____/____ SS# _____

Policy Owner's Employer _____

PLEASE COMPLETE THE BACK SIDE OF THIS FORM

9. Dental History

Is this your child's first visit to the dentist?_____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name & Number_____

_____

Were any x-rays taken at previous dentist? _____

Have there been any injuries to the teeth, face or mouth?_____

If yes, please explain _____

_____

How do you expect your child to act at this visit? _____

_____

Does the child have any of the following habits? (Please circle)

Lip Sucking/Biting Nail Biting Thumb/Finger Sucking

Grind Teeth Clench Jaws Nursing/Bottle Habits

Has the child ever had a serious or difficult problem associated with previous dental work? _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Does the child brush his/her teeth daily? Yes No

Does the child floss daily? Yes No

10. Health History

Has the child ever had any of the following conditions (Please circle)

Abnormal bleeding	Convulsions/Epilepsy	Hepatitis
Allergy to Dyes	Developmental Delay	HIV/AIDS
Allergy to Latex	Diabetes	Kidney/Liver Disease
Asthma	Handicaps/Disabilities	Pacemaker
Autism	Hearing/Speech Impaired	Respiratory Disease
Bleeding Disorder	Heart Disease	Rheumatic Fever
Cancer	Heart Murmur	Thyroid Disease
Cerebral Palsy	Hemophilia/Blood Disorders	Tuberculosis

If no conditions above are circled please initial here _____

If heart murmur was circled, does the child require premedication? _____

Please discuss any other medical conditions/surgeries/hospital stays the child has had

_____

_____

Please list all medications the child is currently taking _____

_____

Please list the child's allergies including medications, latex, dyes, etc. _____

_____

Child's Physician _____Number _____

Child's Cardiologist _____Number _____

Is the child currently under the care of a physician? Yes No

If yes, please explain_____

☐ I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I acknowledge that I have been given a copy of the office's Notice of Privacy Practice. I authorize the dental staff to perform the necessary dental services my child may need. This consent shall remain in effect until cancelled by the parent or guardian. I agree to be responsible for the payment of all rendered treatment on behalf of my dependents.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

Medical History Update

Date _____ Comments _____ Date _____ Comments _____

_____ _____

Parent's Signature _____ Parent's Signature _____

Date _____ Comments _____ Date _____ Comments _____

_____ _____

Parent's Signature _____ Parent's Signature _____

Date _____ Comments _____ Date _____ Comments _____

_____ _____

Parent's Signature _____ Parent's Signature _____

Dr. Rod Stern
Pediatric Dentist

ShiningTeeth4kids.com
516-487-5437

DENTAL TREATMENT CONSENT FORM

Patient(s) Name(s): _____

I, (being the parent or guardian of the above minor patient) do hereby authorize and request the performance of dental services for this patient and the use of whatever procedures Dr. Stern may deem necessary during treatment.

I understand that Dr. Stern and other authorized personnel as he/she may designate to treat the above named patient will use restorative, oral surgery and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Stern. **All treatment and procedures will be discussed with you before the appointment. This authorization is valid until revoked by me in writing.**

I agree to be responsible for full payment of all charges for dental services performed on the above-named patient.

Date: _____

_____

Signature of Parent/Guardian/Self if over 18

_____

Relationship to patient

_____

Witness

Insurance Authorization

I certify that I, and/or my dependent (S), have insurance coverage with _____
Name of Insurance Company (ies)
and assign directly to Dr. Stern all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end my when my current plan is completed or one year form the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relationship to Patient