



Pediatric Patient Information

Email Address: _____

Patients Full Name: _____

Home address: _____

City: _____ State: _____ Zip: _____

Mother/Guardians Full Name: _____

DOB: _____ Social Security#: _____ Employer: _____

Cell Phone: _____ Home Phone: _____

Father/Guardians Full Name: _____

DOB: _____ Social Security #: _____ Employer: _____

Cell Phone: _____ Home Phone: _____

How did you hear about us? _____

Dental Insurance information

Guarantor: _____ Social of guarantor: _____

Insurance company: _____ Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Group # _____ ID# (may be your social): _____

Please fill out if you have dual coverage

Guarantor: _____ Social of guarantor: _____

Insurance company: _____ Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Group # _____ ID# (may be your social): _____

Emergency Contact Information

First and Last name: _____

Cell number: _____

Child Health/Dental History Form



American Dental Association
www.ada.org

Patient's Name LAST FIRST INITIAL			Nickname	Date of Birth																																				
Parent's/Guardian's Name			Relationship to Patient																																					
Address PO OR MAILING ADDRESS CITY STATE ZIP CODE																																								
Phone Home Work			Sex M ☐ F ☐																																					
Have you (the parent/guardian) or the patient had any of the following diseases or problems? ☐ Yes ☐ No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? If you answer yes to any of the three items above, please stop and return this form to the receptionist.																																								
Has the child had any history of, or conditions related to, any of the following: <table border="0"> <tr> <td>☐ Anemia</td> <td>☐ Cancer</td> <td>☐ Epilepsy</td> <td>☐ HIV +/- AIDS</td> <td>☐ Mononucleosis</td> <td>☐ Thyroid</td> </tr> <tr> <td>☐ Arthritis</td> <td>☐ Cerebral Palsy</td> <td>☐ Fainting</td> <td>☐ Immunizations</td> <td>☐ Mumps</td> <td>☐ Tobacco/Drug Use</td> </tr> <tr> <td>☐ Asthma</td> <td>☐ Chicken Pox</td> <td>☐ Growth Problems</td> <td>☐ Kidney</td> <td>☐ Pregnancy (teens)</td> <td>☐ Tuberculosis</td> </tr> <tr> <td>☐ Bladder</td> <td>☐ Chronic Sinusitis</td> <td>☐ Hearing</td> <td>☐ Latex allergy</td> <td>☐ Rheumatic fever</td> <td>☐ Venereal Disease</td> </tr> <tr> <td>☐ Bleeding disorders</td> <td>☐ Diabetes</td> <td>☐ Heart</td> <td>☐ Liver</td> <td>☐ Seizures</td> <td>☐ Other _____</td> </tr> <tr> <td>☐ Bones/Joints</td> <td>☐ Ear Aches</td> <td>☐ Hepatitis</td> <td>☐ Measles</td> <td>☐ Sickle cell</td> <td></td> </tr> </table>					☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/- AIDS	☐ Mononucleosis	☐ Thyroid	☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use	☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis	☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Rheumatic fever	☐ Venereal Disease	☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other _____	☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ Sickle cell	
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Please list the name and phone number of the child's physician: Name of Physician _____ Phone _____																																								

Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. ☐	☐
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. ☐	☐
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. ☐	☐
4. How would you describe the child's eating habits? _____		
5. Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. ☐	☐
6. Has the child ever been hospitalized? _____	6. ☐	☐
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. ☐	☐
8. Has the child ever received a general anesthetic? _____	8. ☐	☐
9. Does the child have any inherited problems? _____	9. ☐	☐
10. Does the child have any speech difficulties? _____	10. ☐	☐
11. Has the child ever had a blood transfusion? _____	11. ☐	☐
12. Is the child physically, mentally, or emotionally impaired? _____	12. ☐	☐
13. Does the child experience excessive bleeding when cut? _____	13. ☐	☐
14. Is the child currently being treated for any illnesses? _____	14. ☐	☐
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. ☐	☐
16. Has the child had any problem with dental treatment in the past? _____	16. ☐	☐
17. Has the child ever had dental radiographs (x-rays) exposed? _____	17. ☐	☐
18. Has the child ever suffered any injuries to the mouth, head or teeth? _____	18. ☐	☐
19. Has the child had any problems with the eruption or shedding of teeth? _____	19. ☐	☐
20. Has the child had any orthodontic treatment? _____	20. ☐	☐
21. What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water		
22. Does the child take fluoride supplements? _____	22. ☐	☐
23. Is fluoride toothpaste used? _____	23. ☐	☐
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. ☐	☐
25. Does the child suck his/her thumb, fingers or pacifier? _____	25. ☐	☐
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities? _____	27. ☐	☐

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/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ☐ Medical Alert ☐ Premedication ☐ Allergies ☐ Anesthesia Reviewed by _____

Date _____



HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the Notice of Privacy Practices as allowed by law.
- The practice has the right to restrict the use of their information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Please read and review our notice before signing this consent.

I have received and reviewed a copy of the Notice Of Privacy Practices.

Print name of Patient

Parent/Guardian Signature

Date

Witness Signature

Date



Individual Release Agreement

Pennington Orthodontics & Pediatric Dentistry

The undersigned enters into this agreement with Pennington Orthodontics & Pediatric Dentistry, and Associates (Producer). I have been informed and understand the above dental office will be using my photographs (product), for marketing purposes.

- 1 I grant Producer, the right to use the product and my name whether recorded on or transferred to videotape, film, slides, other photographs, audiotapes, or other media, now known or later developed. This grant includes without limitation the right to edit, mix, or duplicate and to use or re-use the product in whole or part as Producer, may elect. Producer will have complete ownership of the product in which I appear, including copyright interest, and I acknowledge that I have no interest of ownership in the resulting product or it's copyright.
- 2 I also grant Producer, and its designees the right to broadcast, exhibit, market, sell, and otherwise distribute the product, either in whole or in parts, and either alone or with other products, for advertising allowing Producer or its designees their sole discretion to determine its use. This grant includes the right to use the product for promoting or publicizing any of the uses.
- 3 I confirm that I have the right to enter into this agreement, that I am not restricted by any commitments to third parties, and that producer has no financial commitment or obligations to me as a result of this agreement, I hereby give all clearances, copyright and otherwise, for use of my name, likeness, image appearance and performance embodied in the product. I expressly release and indemnify producer and its officers, employees, agents and designees, from any and all claims known and unknown arising out of or in any way connected with the above granted uses and representations, the rights granted producer herein are perpetual and worldwide.
- 4 Inconsideration of all of the above, I hereby acknowledge receipt of reasonable and fair consideration from producer.

Patient Name: _____

Patient/Guardian Signature: _____ Date: _____

OR

I decline any photographs for social/ electronic media use: ☐



Our 'No Show' Policy

To ensure that each patient is given the proper amount of time for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time.

A NO SHOW fee is charged when you miss your scheduled appointment in the amount of \$75.00 if the appointment is not cancelled within 48 hours prior to the appointment.

Thank You!

Para asegurar que cada paciente reciba la cantidad de tiempo adecuada para su visita y para proporcionar la atencion de mas alta calidad, es muy importante asistir a su visita a tiempo.

UN CARGO se cobrara cuando se pierde su cita por la cantidad de \$75.00 si no ha sido cancelada dentro de 48 horas antes de la cita.

Gracias!

Name on card: _____

Card number: _____

Billing address: _____

Patient/Guardian Signature: _____ Date: _____