Child's Name _____ Date _____

Dental History

How often does your child brush? _____ Floss? _____ Do you assist? _____

Briefly describe any past dental trauma _____

Circle Y or N if your child has had any of the following:

Y / N Bad breath	Y / N Sensitivity to hot/cold	Y / N Loose teeth or broken fillings
Y / N Bleeding gums	Y / N Sensitivity when biting	Y / N Food collection between teeth
Y / N Grinding or clenching teeth	Y / N Sensitivity to sweets	Y / N Sores or growth in mouth
Y / N Clicking or popping jaw	Y / N Finger, thumb or pacifier habit	Y / N Fluoride supplements

Medical History

Name of child's physician _____ Phone # _____

Is your child presently under medical care? Y / N If yes, explain _____

Is your child currently taking medications? Y / N If yes, reason _____

Medications currently taking _____

Has child's physician ever recommended antibiotics for dental treatment? Y / N If yes, reason _____

_____

Does your child see a medical specialist? Y / N If yes, reason _____

Does your child have or has child ever had allergies or reactions? Y / N If yes, circle all that apply:

Penicillin Erythromycin Sulfa Anesthetics Latex Foods (list) _____
Other _____

Circle Y or N if your child has had any of the following medical problems

Y / N Heart disease	Y / N Abnormal bleeding from a cut	Y / N Asthma/breathing problems
Y / N Heart murmur	Y / N Frequent nose bleeds	Y / N Seizures/Epilepsy
Y / N Congenital heart defect	Y / N Unexplained bruising	Y / N Diabetes
Y / N Rheumatic Fever	Y / N Hemophilia/bleeding disorder	Y / N Hepatitis
Y / N Mononucleosis (Mono)	Y / N Anemia	Y / N HIV+/AIDS
Y / N Bone problems	Y / N Blood transfusions	Y / N Cancer

Other medical conditions _____

Authorization, Acknowledgement and HIPAA: The permission of a parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in Doctor's professional judgement to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform the office of any changes in my child's health status or contact information. I have also been informed of this office's privacy policies which are in accord with the HIPAA Act of 2003.

I authorize Doctor to take x-rays, study models, photographs or other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated with my child. I further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I authorize my current insurance to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions and for the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all changes whether or not paid by insurance. I understand that responsibility for payment for Dental Services provided in this office for my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 22% finance charge will be added to any balance over 90 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

I have been informed of Palo Verde Smiles' privacy policies which are in accord with the HIPAA Act of 2003.

_____

Parent/Responsible Party Signature Date Relationship to Child