Treasured Smiles
PEDIATRIC DENTISTRY, LTD
Specializing in Dentistry for Children and Adolescents

Dental and Medical Health History

Today's Date: _____

Child's Name:_____Age:_____Date of Birth:_____

Nick Name:_____School:_____Grade: _____

Child's Dental History

Is this your child's first dental visit? ☐Yes ☐No _____ Previous Dentist's name

Is there a reason for today's appointment? ☐Yes ☐No _____ Explain Concern

Have there been any injuries to the teeth? ☐Yes ☐No _____ What teeth, when, how

Does your child have a thumb, finger or pacifier habit? ☐Yes ☐No _____ How often

Has your child had any unfavorable dental experiences? ☐Yes ☐No _____ Please Explain

Who brushes the child's teeth?_____How many times per day?_____Flossing?_____

Child's Medical History

Physician's Name:_____City:_____Phone: (_____)_____

Is your child being treated by a physician at this time? ☐Yes ☐No _____ Condition /Reason for treatment

Does your child require pre-medication prior to dental visits? ☐Yes ☐No _____ Please Explain

Is your child taking any medications at this time? ☐Yes ☐No _____ Please list all medications

Does your child have any allergies? (food,drug,etc.) ☐Yes ☐No _____ Please list allergens

Has your child ever been hospitalized? ☐Yes ☐No _____ Reason for hospitalization

Does your child have or has your child had any of the following conditions?

☐Anemia	☐Diabetes	☐Asthma	☐Ear Infections
☐HIV/AIDS	☐Kidney Disease	☐Respiratory Disease	☐Hearing problems
☐Heart problem	☐Liver Disease	☐Sinus Problems	☐Eye Problems
☐Heart Murmur	☐Jaundice	☐Seasonal Allergies	☐Learning Disability
☐Hemophilia	☐Hepatitis	☐Bronchitis	☐Seizures/Epilepsy
☐Rheumatic Fever	☐Arthritis/Joint Pain	☐Pneumonia	☐ADHD
☐Leukemia	☐Cancer/Chemotherapy	☐Tuberculosis	☐Muscle Disease

Are there any other medical or dental conditions that you feel we should know about your child?_____

_____

Please explain any of the above conditions checked: _____

_____

Signature_____Date_____

****Please Complete the Reverse Side of This Form****

Consent for Treatment

Consent for treatment for _____
(child's name)

I request and authorize Dr. Steven Kuhn, Dr. Dennis LaMonte and Dr. Hilary Habel, assisted by dental auxiliaries of their choice, to examine, clean, apply fluoride, and provide treatment for my child's teeth. I further request and authorize the taking of any necessary dental x-rays needed to diagnose and/or treat my child's dental condition. In addition, photographs may be taken of my child and their teeth for diagnostic and educational purposes. I acknowledge that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Furthermore, the doctors provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and variable voice tone.

Signature of Patient or Guardian _____ Date _____

Authorization to Share Protected Health Information (PHI)

I hereby authorize Treasured Smiles Pediatric Dentistry, Ltd. to release any medical/dental information as requested to the individuals I list below. The information that may be released will include, but is not limited to, medical/dental records, insurance information, appointment information, account information, and treatment information. This information can be released by phone, in person, by mail or via email.

I am aware that Treasured Smiles Pediatric Dentistry, Ltd. cannot control how the recipient uses or shares this information and laws protecting its confidentiality may or may not protect this information once it has been disclosed to the recipient.

I understand that I may revoke this authorization at any time by notifying Treasured Smiles Pediatric Dentistry, Ltd. in writing. I may see and copy the information described on this form if I ask for it and I am not required to sign this form to receive dental treatment.

Patient Name _____ Date of Birth _____

Release my protected health information to the following person(s) upon request:

Name: _____ Relationship _____

Name: _____ Relationship _____

The patient must sign this form to authorize Treasured Smiles Pediatric Dentistry, Ltd. to release his/her PHI. If the patient cannot sign, only the patient's legal representative may sign. Patients 18 years or older must sign the form on their own behalf.

Signature of Patient or Patient's Representative _____ Date _____

Printed name of Patient's Representative (if applicable): _____

Relationship to Patient: _____