Changes in Medical History

Patients Name:________________________ **Date:**______________

Address: ____________________________________

City: __________ State: ________ Zip: ________

Cell: __________________ Home: ________________

Circle which is best to confirm appointments? CELL or HOME

Email: ____

Please answer applicable questions by circling and elaborate below if "Yes"

Does your child have any health problems?__________________________ Yes / No

Has your child seen a physician in the last year?______________________Yes / No

Has your child ever been hospitalized?____________________________Yes / No

Does your child take medicines regularly?__________________________Yes / No

Is your child taking vitamins with iron?____________________________Yes / No

Is your child allergic to penicillin or other substances?________________Yes / No

Does your child have an emotional or nervous condition?______________Yes / No

Has your child ever had a history of: (please write "Yes" or "No" and elaborate below)

______Special Needs ______Heart Murmur ______Asthma ______Bleeding Disorder
______Heart Trouble ______Anemia ______Diabetes ______Rheumatic Fever

______Speech Problems _____ Tuberculosis ______Kidney/ Liver Disorder

______Epilepsy/Convulsions ______Any unusual conditions

If answered "Yes" to the question above, please explain___________________________

____

To the Best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or medicines, I will inform the doctors. I hereby authorize treatment by the doctors in caring for my child.

Additional Comments:____

____

Office Policy

- ***There will be a fee of $20 per child for release of x-rays or medical forms.***
- ***If you cannot make your appointment, we require 24 hour notice. If for any reason appointments are not cancelled within 24 hours, there will be a $25 fee assessed per child.***
- ***We reserve the right to charge a $25 reservation fee for prime time appointments, this includes all school holidays, summer vacations and after school appointments after 3pm.***

Signature:__________________________ **Date:**______________

Informed Consent

I hereby authorize and direct Dr. Mila Davis and or associate dentist of Healthy Smiles Children's Dentistry, assisted by dental auxiliaries of her choice, to perform upon my child (or legal ward whom I consent) dental services that in their judgment are advisable, including the use of nitrous oxide analgesic gas, and x-rays of my child for dental records, with the exception of:__________________________________

Although their occurrence is not frequent, some risks and complications are known to be associated with pediatric treatment including nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risk of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown or extracted tooth, injury to tongue, lips or cheek, damage to and the possible loss of existing teeth and or fillings, injury to nerves near the treatment site, fracture to a tooth root which may require additional surgery for its removal. I understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it.

Signature:______________________________**Date:**_______________

Parent Guidelines

Dear Parents,

You may choose whether or not you accompany your child to his/ her dental appointment. Although we sense that some children do better without parents present, we are open to having you with your child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

1. **Allow us to prepare your child**
2. **Be supportive of the practice's terminology.**
3. **Please be a silent observer-support your child with touches.**
   - A. **This allows us to maintain communication with your child.**
   - B. **Children will normally listen to their parents instead of us and may not hear our guidance.**
   - C. **You might give incorrect or misleading information.**
4. **If asked to leave, be ready to immediately walk away.**
   - A. **Many children will try to control the situation.**
   - B. **"Acting out" is normal, but unacceptable during fillings**
   - C. **This is intended to "short circuit" the control attempt.**
   - D. **We will continue to support your child at all times.**

These are very important ways that you can actively help in the success of your child's visit. We are confident that all will go well and hope these guidelines will prepare you with confidence for your child's upcoming appointment.

Signed:__________________________________**Date:**________________

Acknowledgement of Receipt of Notice of Privacy Practices

Healthy Smiles Children's Dentistry

You May Refuse to Sign This Acknowledgment

I have received a copy of this office's Notice of Privacy Practices.

Print name: ______________________________

Signature: ______________________________

Date: ______________________________

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

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Media Consent Forms

I consent that *Healthy Smiles Children's Dentistry* may use photographs or videos of ______________________________ (patient name) on their media mediums. I consent that these may be placed on the following (circle the ones in which you give us permission and place your initial on the line beside each):

Facebook ____________

Testimonials ____________

Website ____________

Office "No Cavity Club" Board ______________

Minor/Patient Name: ____

Guardian Name: ____

Guardian Signature:

Date: