

## Child Dental History

Is this your child's first visit to the dentist? \_\_\_\_\_ If not, how long since the last dental visit? \_\_\_\_\_  
Has your child had any problem with dental treatment in the past? \_\_\_\_\_  
Has your child ever had dental x-rays? \_\_\_\_\_ Have any cavities been noted in the past? \_\_\_\_\_  
Has your child had any trouble with the eruption or shedding of teeth? \_\_\_\_\_  
Have any teeth (baby or permanent) been removed by extraction? \_\_\_\_\_  
Have there been any injuries to teeth such as fractures, chips, etc.? \_\_\_\_\_  
Has your child had any orthodontic treatment? \_\_\_\_\_  
How many times are your child's teeth brushed each day? \_\_\_\_\_ When are they brushed? \_\_\_\_\_  
Is fluoride toothpaste used? \_\_\_\_\_ What type of water does your child drink? \_\_City \_\_Well \_\_Bottled \_\_Rural  
Does your child take fluoride supplements? \_\_\_\_\_ Does your child suck his/her thumb, fingers or pacifier? \_\_\_\_\_  
Does your child eat sweets such as candy, soda pop, or chewing gum? \_\_\_\_\_ How often? \_\_\_\_\_

## Health History

Name of Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Is your child taking any medications at this time? If yes, please list: \_\_\_\_\_

Is your child allergic to penicillin, antibiotics, or other medications? If yes, please list: \_\_\_\_\_

Is our child allergic to anything else, such as certain foods? If yes, please explain: \_\_\_\_\_

Has your child ever had a serious illness? If yes, when: \_\_\_\_\_ Please describe: \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_ Please describe: \_\_\_\_\_

Has your child had a history of any other illnesses? Please describe: \_\_\_\_\_

Has your child ever received a general anesthetic? \_\_\_\_\_ Ever had a blood transfusion? \_\_\_\_\_

Does your child have any inherited problems? \_\_\_\_\_ Speech difficulties? \_\_\_\_\_

Is your child physically, mentally, or emotionally impaired? \_\_\_\_\_

Does your child had a persistent cough greater than three weeks or cough that produces blood? \_\_\_\_\_

Does your child experience excessive bleeding when cut? \_\_\_\_\_

Is your child currently being treated for any illnesses? \_\_\_\_\_

### Has the child had any history of, difficulty with, or diagnosis of any of the following:

<input type="checkbox"/> Anemia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Bladder
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Mouth Breather	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy / Seizures
<input type="checkbox"/> Fainting	<input type="checkbox"/> Growth problems	<input type="checkbox"/> Hearing	<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Kidney
<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Liver	<input type="checkbox"/> Stroke	<input type="checkbox"/> Measles
<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Sickle cell	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Tobacco/Drug use
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Other _____	

I certify that I have read and understand the above and that my answers are complete and accurate. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I understand it is my responsibility to inform this office of any changes in medical status.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Relation to child** \_\_\_\_\_

Doctor	Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____
Review	Date _____	Initials _____	Date _____	Initials _____	Date _____	Initials _____

# Child Acquaintance Form

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

## Patient/Parent or Guardian Information

Date \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ Patient's Birthdate (m)\_\_\_\_(d)\_\_\_\_(y)\_\_\_\_  
Patient's Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Patient's Sex \_\_ Male \_\_ Female Age \_\_\_\_\_  
Patient's Social Sec. # \_\_\_\_\_  
Father/Guardian's Name \_\_\_\_\_ Father/Guardian's Employer \_\_\_\_\_  
Father/Guardian's Occupation \_\_\_\_\_ How long? \_\_\_\_\_  
Father/Guardian's Business Phone (\_\_\_\_) \_\_\_\_\_ Father/Guardian's Cell Phone (\_\_\_\_) \_\_\_\_\_  
Father/Guardian's Birthdate (m)\_\_\_\_(d)\_\_\_\_(y)\_\_\_\_  
Mother's Name \_\_\_\_\_ Mother's Employer \_\_\_\_\_  
Mother's Occupation \_\_\_\_\_ How long? \_\_\_\_\_  
Mother's Business Phone (\_\_\_\_) \_\_\_\_\_ Mother's Cell Phone (\_\_\_\_) \_\_\_\_\_  
Mother's Birthdate (m)\_\_\_\_(d)\_\_\_\_(y)\_\_\_\_  
Whom may we thank for referring you? \_\_\_\_\_  
Person to contact in emergency \_\_\_\_\_ Emergency Phone (\_\_\_\_) \_\_\_\_\_  
Person responsible for account \_\_\_\_\_ Relation to patient \_\_\_\_\_

## Dental Insurance

Insured's Name \_\_\_\_\_ Relation to patient \_\_\_\_\_  
Insured's Birthdate (m)\_\_\_\_(d)\_\_\_\_(y)\_\_\_\_ Social Sec. # \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ How Long? \_\_\_\_\_  
Business Address \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Group # \_\_\_\_\_ Identification # \_\_\_\_\_

**Please let our receptionist copy your insurance card. Thank you.**

## Insurance Authorization

I hereby authorize the office of Brant P. Rouse, D.D.S., PLC to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all health benefits due to my dependents and me. I also authorize payment of healthcare benefits otherwise payable to me, directly to my dentist as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## Acknowledgement of receipt of Notice of Privacy Practices

I \_\_\_\_\_ (print name) have received a copy of this office's Notice of Privacy Practices.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

### Office use only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: \_\_ Individual refused to sign \_\_ Communication barrier \_\_ Emergency situation \_\_ Other \_\_\_\_\_