

PATIENT INFORMATION FORM

NAME \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ DATE O BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIPCODE \_\_\_\_\_

HOME PHONE \_\_\_\_\_ OWN/RENT \_\_\_\_\_ YRS. CELLPHONE# \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ PAGE# \_\_\_\_\_

PATIENT/PARENT NAME \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYED BY \_\_\_\_\_ YEARS EMPLOYED \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ DRIVER LIC# \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE \_\_\_\_\_

SPOUSE/PARENT NAME \_\_\_\_\_ SS# \_\_\_\_/\_\_\_\_/\_\_\_\_ D.O.B \_\_\_\_/\_\_\_\_/\_\_\_\_

EMPLOYED BY \_\_\_\_\_ YEARS EMPLOYED \_\_\_\_\_

EMPLOYERS ADDRESS \_\_\_\_\_ DRIVERS LIC.# \_\_\_\_\_

CITY \_\_\_\_\_ ZIP CODE \_\_\_\_\_ PHONE \_\_\_\_\_

NEAREST RELATIVE NOT LIVING WITH YOU \_\_\_\_\_

PHONE \_\_\_\_\_

CELL \_\_\_\_\_

NEAREST FRIEND NOT LIVING WITH YOU \_\_\_\_\_

PHONE \_\_\_\_\_

CELL \_\_\_\_\_

WHOM MAY WE CONTACT IN CASE OF AN EMERGENCY \_\_\_\_\_

PHONE \_\_\_\_\_

CELL \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? \_\_\_\_\_

DOES THIS PERSON HAVE INSURANCE ? \_\_\_\_\_ YES \_\_\_\_\_ NO (YES, FILL OUT INSURANCE FORM

WHOM MAY WE THANK FOR REFERRING YOU TO US? \_\_\_\_\_

FORM FILLED OUT BY \_\_\_\_\_

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I understand all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. \_\_\_\_ (INTL)

**I will notify you of any changes in the above information. \_\_\_\_ (INTL)**

**I authorize the release of any information necessary to process my insurance claim. \_\_\_\_ (INTL)**

**I hereby authorize payment to the dentist of the insurance benefits other wise payable to me.**

**A copy of this signature is as valid as the original. \_\_\_\_ (INTL)**

**If insurance check is sent to me in error, I will forward it to doctor's office immediately.**

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

# CHARLES L. LUTZ

GENTLE DENTAL CARE

[www.charleslutzdds.com](http://www.charleslutzdds.com)

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## ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

**Payment for services is due at time services are rendered** unless payment arrangements have been approved in advance by our staff, in which a credit report may be requested.

We accept cash, checks, American Express, Mastercard, or Visa. We will be happy to help you process your insurance claim-form for reimbursement.

Returned checks and balance older than 30 days may be subject to additional collection fees and interest charges of 1.25% per month. **Charges of \$100.00 may also be assessed if not cancelled within 24 hours.** \_\_\_\_\_(intl)

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. **The percentage of coverage by your insurance company may be based on the company's own reduced fee schedule for dental services and may be less than actual charges resulting in lower coverage for you. We have no control over this situation. Lower payment is a direct result of the plan selected by your employer. Please be advised that WE CANNOT WAIVE CO-PAYMENT. We are required by law to COLLECT CO-PAYMENT.**
2. **Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.**  
\_\_\_\_\_(intl)
3. **Any balance not paid will be subject to small claims court or reported on your credit.**\_\_\_\_\_(intl)

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. **While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.**\_\_\_\_\_(intl) We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, **PLEASE don't hesitate to ask us. We are here to help you.**



# Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<b>(Check DK if you Don't Know the answer to the question)</b>			<b>Yes No DK</b>				<b>Yes No DK</b>				
Do you wear contact lenses? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Joint Replacement.</b> Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED					
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____					
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____					
<b>Allergies</b> - Are you allergic to or have you had a reaction to: To all <b>yes</b> responses, specify type of reaction.			<b>Yes</b>	<b>No</b>	<b>DK</b>				<b>Yes</b>	<b>No</b>	<b>DK</b>
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.</b>											
			<b>Yes</b>	<b>No</b>	<b>DK</b>				<b>Yes</b>	<b>No</b>	<b>DK</b>
Artificial (prosthetic) heart valve .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Previous infective endocarditis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged valves in transplanted heart .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus. ....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart disease (CHD)						Asthma .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unrepaired, cyanotic CHD .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired (completely) in last 6 months .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repaired CHD with residual defects .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						Tuberculosis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Yes</b>	<b>No</b>	<b>DK</b>	Chest pain upon exertion .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular disease. ....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Angina .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arteriosclerosis .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congestive heart failure .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Damaged heart valves.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other congenital heart defects .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Hepatitis, jaundice or liver disease .....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Charles L. Lutz D.D.S.

# CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

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## SECTION A: PATIENT GIVING CONSENT

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Patient Number: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

**Contact Person: Carla Padilla**

**Telephone: (559) 673-3581 Fax: (559) 673-5063**

**E-mail: clutzdds@sbcglobal.net**

**Address: 121 N "I" St Madera, Ca 93637**

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

## SIGNATURE

I, \_\_\_\_\_, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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Charles L. Lutz, DDS

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

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

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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## For Office Use Only

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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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
© 2002 American Dental Association  
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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

**YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
Include completed Consent in the patient's chart.**

**REVOCACTION OF CONSENT**

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# 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 <input type="checkbox"/> F <input type="checkbox"/>	
Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? <b>If you answer yes to any of the three items above, please stop and return this form to the receptionist.</b>				
<b>Has the child had any history of, or conditions related to, any of the following:</b>				
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> Sick cell
<input type="checkbox"/> Thyroid				
<input type="checkbox"/> Tobacco/Drug Use				
<input type="checkbox"/> Tuberculosis				
<input type="checkbox"/> Venereal Disease				
<input type="checkbox"/> Other _____				
<b>Please list the name and phone number of the child's physician:</b>				
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. <input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. <input type="checkbox"/>	<input type="checkbox"/>
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. <input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized? .....	6. <input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7. <input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic? .....	8. <input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems? .....	9. <input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties? .....	10. <input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion? .....	11. <input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired? .....	12. <input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut? .....	13. <input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses? .....	14. <input type="checkbox"/>	<input type="checkbox"/>
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. <input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past? .....	16. <input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed? .....	17. <input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth? .....	18. <input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth? .....	19. <input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment? .....	20. <input type="checkbox"/>	<input type="checkbox"/>
21. <b>What type of water does your child drink?</b> <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water		
22. <b>Does the child take fluoride supplements?</b> .....	22. <input type="checkbox"/>	<input type="checkbox"/>
23. <b>Is fluoride toothpaste used?</b> .....	23. <input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. <input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier? .....	25. <input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27. Does child participate in active recreational activities? .....	27. <input type="checkbox"/>	<input type="checkbox"/>

**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 \_\_\_\_\_