CHILD DENTAL HISTORY

Why have you come to the dentist today?_____

Name of child's previous dentist:_____ City / State: _____

When did child see dentist last?_____ Did child have X-rays taken at that time? ❑ Yes ❑ No

What was the reason for child seeking dental treatment at that time? ❑ Routine exam ❑ Teeth cleaning ❑ Special problem

If special problem, please explain: _____

Yes	No	
❑	❑	Has child previously complained about dental problems? Please explain: _____
❑	❑	Is child extremely nervous or anxious while receiving dental treatment? Please explain:_____
		_____
❑	❑	Has child had any injuries to the mouth, teeth or head? Please explain:_____
		_____
❑	❑	Does child have any mouth habits (thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, sippy cup, etc.)?
		_____
❑	❑	Does child have unusual speech habits? Please explain: _____
❑	❑	Has child worn orthodontic appliances now or in the past? Please explain:_____
❑	❑	Is child assisted with tooth brushing? How often are the child's teeth brushed?_____times daily _____times weekly
		How often are child's teeth flossed? _____times daily _____times weekly
❑	❑	Does child use toothpaste? What type? _____
❑	❑	Is child's drinking water fluoridated?
❑	❑	Is child taking fluoride in any other form? Please explain: _____
❑	❑	Has any member of the family ever had an unusual dental history, such as missing or extra teeth? Please explain:
		_____
❑	❑	Does child snack or frequently consume sugar such as gum, soda pop, Life Savers or fruit juices? Please explain:
		_____

For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

Medical History Update:

1. Date: _____ Comments:_____ Signature: _____
2. Date: _____ Comments:_____ Signature: _____
3. Date: _____ Comments:_____ Signature: _____
4. Date: _____ Comments:_____ Signature: _____
5. Date: _____ Comments:_____ Signature: _____
6. Date: _____ Comments:_____ Signature: _____
7. Date: _____ Comments:_____ Signature: _____
8. Date: _____ Comments:_____ Signature: _____

FADI IBSIES, DMD

18750 SW WILLAMETTE DR., SUITE B-2 • WEST LINN, OR 97068

PHONE: 503.607.2222

CHILD HEALTH HISTORY

PARENT/GUARDIAN: The purpose of the following is to determine if your child has a medical condition that may require special care. All information is confidential and kept in your child's dental record. Please complete this form and remain in the dental office while your child is receiving treatment.

Name: _____ Birthdate____/____/____

Child prefers to be called: _____

Date of child's last medical examination: ____/____/____ Current Height: _____feet _____inches

Reason: _____ Current Weight: _____pounds

Medical History

Pediatrician Name: _____

Address _____

_____
City State Zip

Phone #: ( ) _____

Child's current physical health is: ❑ Good ❑ Fair ❑ Poor

Is child currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

_____

Does your child use tobacco in any other form? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Barbiturates	Y N Jewelry	Y N Seasonal
Y N Codeine	Y N Latex	Y N Sulfa Drugs
Y N Dental Anesthetics	Y N Other_____	

Please list additional drugs that cause allergic reactions: _____

_____

_____

For Women: Is child taking birth control pills? ❑ Yes ❑ No

Is child pregnant? ❑ Unsure ❑ Yes, week #:____ ❑ No

Is child nursing? ❑ Yes ❑ No

Is child taking any prescriptions or over-the-counter drugs? ❑ Yes ❑ No

If yes, please list each one: _____

Please indicate if this child has ever been <u>diagnosed</u> or <u>treated</u> for any of the following:

Y N Abnormal Bleeding	Y N Emphysema	Y N Liver Disease
Y N Alcohol Abuse/Drug Abuse	Y N Epilepsy/Seizures	Y N Mitral Valve Prolapse
Y N Anemia	Y N Fainting Spells	Y N Pacemaker
Y N Arthritis	Y N Frequent/Severe Headaches	Y N Persistent Cough
Y N Artificial Bones/Joints	Y N Glaucoma	Y N Psychiatric Problems
Y N Artificial Heart Valves	Y N Hay Fever	Y N Radiation Treatment
Y N Autoimmune Disease	Y N Heart Attack	Y N Rheumatic Fever
Y N Asthma	Y N Heart Murmur	Y N Scarlet Fever
Y N Blood Transfusion	Y N Heart Surgery	Y N Sinus Problems
Y N Cancer	Y N Hepatitis Type _____	Y N Steroid Therapy
Y N Chemotherapy	Y N Herpes/Fever Blisters	Y N Stroke
Y N Colitis/Ulcers	Y N High/Low Blood Pressure	Y N Thyroid Problems
Y N Congenital Heart Defect	Y N HIV+/AIDS	Y N Tuberculosis (TB)
Y N Diabetes	Y N Kidney Problems	Y N Venereal Disease
Y N Difficulty Breathing		

List any serious medical condition(s) that the child has experienced:

_____

Yes	No	
❑	❑	Was child born of a normal 9 month pregnancy? If premature, how many months?_____ Birth weight:_____lbs._____oz.
❑	❑	Is child physically or mentally handicapped in any way? If yes, how: _____
❑	❑	Does child need an update on immunizations? Has child ever received general anesthesia or sedation? ❑ Yes ❑ No
❑	❑	Is child in the grade appropriate for his/her age?

I have answered these questions for the patient (child) to the best of my knowledge and ability.

_____

Signature of parent or legal guardian Date

PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION.

Authorization and Release

If you have dental insurance, we will prepare and submit your dental claims as a courtesy to you.

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

I acknowledge that I am financially responsible for all changes whether or not they are covered by insurance. I hereby authorize payment directly to West Linn Dental of the group insurance benefits otherwise payable to me. I also authorize release of any information including this diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including rebilling & interest charges, missed appointment fees, all collection costs and reasonable attorney fees. Any accounts sent for collections will be assessed an additional $100 processing fee.

We appreciate your keeping your scheduled appointments. We reserve time & expertise exclusively for you because you are important to us. If you should need to change or cancel your appointment, we kindly ask you give 48 hours notice. Appointments cancelled without 48 hours notice or failed appointments may be assessed a fee of $25 per half hour of scheduled time.

Payment plans and special arrangements must be made ***prior*** to treatment & approved by our office manager. Returned checks will be charged a flat rate of $25.00 per check per incident. Balances older than 60 days from the date of service, regardless of insurance, may be subject to the following interest charges. Interest is calculated at a rate of 1.5% per month (or 18% annually or a $5.00 rebilling fee (whichever is greater)) and applied monthly to unpaid account balances.

For your convenience, we accept most major credit cards. We also offer additional payment plans through an outside financing group. If you would like more information or have any questions, please let us know. We are happy to help.

Name *(Please print):*_____

Signature:_____ **Date:** _____

Patient:_____

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WELCOME

Thank you in advance for your coming to see us today. In order for us to better serve you, please take a few moments to complete this entire form. At Smile Linn Dental, we are committed to keeping your private healthcare information confidential.

Today's Date: _____

Person Financially Responsible for Account (parent's name if minor):

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____

❑ Male ❑ Female Birthdate: ____/____/____ Age: _____

Social Security #: _____

Driver's License #: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone: (____)_____ Pager: (____) _____

Work Phone: (____)_____ Ext: _____

Cell Phone: (____) _____

E-mail: _____

Employer:

Employer's Name: _____

Employer's Address: _____

_____
City State Zip

Length of employment: _____

Occupation: _____

When are the best times to reach you? _____am _____pm

Whom may we thank for referring you? _____

_____

Second Person Responsible for Account/Spouse:

Name: _____ Birthdate: ____/____/____

Employer: _____

Driver's License #: _____

Work Phone: (____)_____ Home Phone: (____) _____

Relationship: _____

Social Security #: _____

Billing Address: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group Number (Plan, Local or Policy #): _____

Insured's Name: _____ Birthdate: ____/____/____

Relationship to Patient: _____

Insured's SS #(required): _____

Insured Insurance ID #: _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: (____) _____

Group Number *(Plan, Local or Policy #)*: _____

Insured's Name: _____ Birthdate: ____/____/____

Relationship: _____

Insured's SS #: (required) _____

Insured's Employer: _____

Employer's Address: _____

_____
City State Zip

In the event of any emergency, whom should we contact?

Name: _____

Relation: _____

Work Phone: (____) _____

Home Phone: (____) _____

Cell Phone: (____) _____

Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
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