KIND

HEALTH HISTORY QUESTIONNAIRE

Email:

Patient Name *(Last, First, M.I.):* ☐ M ☐ F	**DOB:**
Address: **City:** **State:** **Zip Code:**	
Home Phone: **Cell Phone:**	**Reason for today's visit:** ☐6Month ☐Pain☐ Other_____

PATIENT HEALTH HISTORY

Childhood illness:
Please Answer the Following Questions for Patient: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐Rheumatic Fever ☐ Polio ☐ Jaundice

Please check any that currently apply

☐ ADD ☐ ADHD	☐ Bleeds Easily	☐ Diabetes Type_____
☐ Autism	☐ Hay Fever	☐ Leukemia / Cancer
☐ Allergies to_____	☐ Genetic Disorder	☐ Tuberculosis
☐ Anemia	☐ Heart Disease	☐ Hepatitis A
☐ Asthma	☐ Heart murmur	☐ Hepatitis B
☐ Developmental Delays	☐ Rheumatic Fever	☐ Hepatitis C
☐ Down Syndrome	☐ Cystic Fibrosis	☐ HIV/AIDS
☐ Speech Delays	☐ Snoring	☐ Kidney Disease
☐ Respiratory Problems	☐ Epilepsy / Seizures	☐ Blind
☐ Tuberculosis	☐ Joint Replacement	☐ Pregnant
☐ Hearing Problems	☐ Liver Disease	☐ OTHER_____
☐ Low Blood Pressure	☐ High Blood Pressure	☐ **NONE OF THE ABOVE (PARENT INITALS)** _____

Health History

Is the patient currently taking any medications? ☐ Yes ☐ No

If yes please list all medications including over the counter Medication being taken _____

Does the patient have any allergies? ☐ Yes ☐ No If yes please explain_____

Has the patient been hospitalized in the last 5 years? ☐ Yes ☐ No If yes please explain_____

Patient Dental Health History

Has the patient ever had and unhappy dental experience? ☐ Yes ☐ No

Dose the patient floss daily? ☐ Yes ☐ No

Does the patient have any habits such as mouth breathing sleeping with a bottle or zippy cup or thumb sucking? ☐ Yes ☐ No

Does the patient brush daily? ☐ Yes ☐ No

Do the gums bleed while flossing or brushing? ☐ Yes ☐ No

Is the patient exercising any pain? ☐ Yes ☐ No

Is the patients' teeth sensitive to hot or cold Liquids or foods? ☐ Yes ☐ No

Has the patient ever had and unhappy dental experience? ☐ Yes ☐ No

Does the patient have any sores or lumps in mouth? ☐ Yes ☐ No

Does the Patient clench or grind their teeth? ☐ Yes ☐ No

Has the patient ever suffered any trauma to the face, mouth, or jaw? ☐ Yes ☐ No

Has the patient ever had braces? ☐ Yes ☐ No

Last time patient had a dental exam Date:_____

All questions contained in this questionnaire are strictly confidential and will become part of your medical/dental record.

I certify that I have read and understand the above information to the best of my knowledge; the above questions have been answered accurately. I understand the providing false or incorrect information can be dangerous to my child's health.

Parent/Guardian Name_____ Parent/Guardian Signature_____

Dentist Signature_____ Date_____

Has the patient ever had a blood transfusion?	☐ Yes	☐ No	
Have you ever had complications following dental treatment?	☐ Yes	☐ No	Explain_____
Is the patient currently under the care of a physician?	☐ Yes	☐ No	Explain_____
Is the patient currently taking any medications?	☐ Yes	☐ No	If yes, please list all medications including over the counter
			Medication being taken_____
Does the patient have any allergies?	☐ Yes	☐ No	If yes, please explain_____
Has the patient been hospitalized in the last 5 years?	☐ Yes	☐ No	If yes, please explain_____

Medical Health Information			
Name of Pediatrician:	**Last Exam:**	**Reason For Visit:**	
Address:	**City:**	**State:**	**Zip Code:**
Phone:	**Fax:**		

Parent Guardian Information			
Mothers Name:	**DOB:**	**SSN:**	
Address:	**City:**	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**		
Fathers Name:	**DOB:**	**SSN:**	
Address:	**City:**	**State:**	**Zip Code:**
Home Phone:	**Cell Phone:**		

INSURANCE INFORMATION			
Approved for discount program	☐ Yes	☐ No	
Medicaid	☐ Yes	☐ No	If yes ID #
CHP+	☐ Yes	☐ No	If yes ID #
Private Insurance	☐ Yes	☐ No	

Please list any other concerns whether medical or dental:

I certify that I have read and understand the above information to the best of my knowledge; the above questions have been answered accurately. I understand the providing false or incorrect information can be dangerous to my child's health.

Parent/Guardian Name_____ Patient Name_____

Signature_____ Date_____

As a reminder to all patients' parents payment is due at time of service. If you have any questions, please let the front office staff know. Thanks!

Office Use only

Dentist Signature_____ Date_____

Notes:

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing your child 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 this goal, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are provided unless payment arrangements have been approved in advance by our office manager or business assistant. We accept cash, check, Visa, and Master Card.

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

1. Your insurance is a contract between you, and the insurance company. We are not a party to that contract.
2. Most insurance companies have a co payment that must be paid, and the insurance company will pay their portion. You are responsible for all balances on your account.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as a dental care provider, 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 services are provided.

If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask us; we are here to help you.

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING TODAY BY: CASH ☐ CHECK ☐ CREDIT CARD ☐

NO SHOW POLICY

Your appointment time is set aside especially for you. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we would appreciate a 24-hour notice. Repeated cancellations or failures will result in a broken appointment charge of $20.00 and/or no reappointment.**

I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services provided. I have read and understand the above information.

_____**Parent initials**

Patients Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Further treatment with other health or dental care providers to complete on the dental procedures, such as extractions, fillings, etc...
- The day-to-day healthcare operations of your practice.

I have been informed of, and given, the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of the notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment , payment, and health care operations, but that you are not required to agree to these requested restrictions, However, any use or disclosure that occurred prior to the date revoking this consent is no affected.

Patients Name: _____

Parent/Guardian Print: _____

Parent/Guardian Signature: _____Date: _____

AUTHORIZATION TO TREAT A MINOR

I, as the Parent/Guardian of _____ am legally able to make all medical/dental decisions for said child. I understand that by signing this form, all responsibility for consenting to proposed and performed treatment is my decision, and I do not legally need to consult anyone else in order to authorize treatment.

Sometimes, as you know, the very young child still refuses to cooperate. The following are the techniques that could be used to gain your child's cooperation and/or control their bodily movements.

Please initial each technique:

_____Show, Tell and Do. This technique demonstrates to a limited degree what the dentist and his/her staff will do. Your child may be given a simple explanation of a procedure and be allowed to see, touch and/or handle the objects or instruments that are used.

_____Positive Reinforcement. The use of words that help to shape your child's behavior, in a positive manner.

_____Voice Control. Using different tones of voice to cue your child as to how they are behaving. Most children respond favorable to voice changes.

_____Nitrous Oxide/Oxygen. Conscious sedation to reduce anxiety.

The above listed behavior management techniques have been explained to me. I hereby authorize the Dentist/Staff to utilize these techniques to assist in the necessary treatment for my child. I understand that this consent shall remain in effect until terminated by me in writing.

_____**Parent initials**

PERMISSION FOR DENTAL TREATMENT

Your child has been, or will be, examined by our dentist and may need dental care. This form describes the possible dental treatments that your child may receive. Please review the description of treatment and ask any questions before signing this form. When this form has been signed your child may be treated in our facilities.

1. Dental Filling: Decay slowly destroys tooth structure and if not treated, may result in an abscessed tooth causing pain and infection. The dentist will remove the decayed part of the tooth and replace it with a silver or tooth colored resin filling. A local anesthetic will be used to numb the area being treated. The area will be numb for 2-4 hours after treatment.
2. Stainless Steel Crown: If a tooth is badly destroyed by decay, a filling will not stay in place. Therefore, a tooth is prepared for a crown or "cap" can be placed on top of it to prevent the tooth from breaking. As with a filling, the area being treated will be given a local anesthetic and will be numb for 2-4 hours after treatment.
3. Nerve or Pulp Treatment: When decay or infection is so great that it has infected the nerve of the tooth, nerve tissue must be removed from the tooth. A special filling will be placed inside the tooth and will be covered by a crown. During this treatment the area will be treated with a local anesthetic, numbing the area for 2-4 hours after the treatment.
4. Extraction/Removal of Tooth: If infection or decay has spread too far and the tooth is non-restorable, the infected tooth must be taken out. After numbing the area with local anesthetic, the tooth is removed and the area is packed with gauze to control bleeding. Further instruction will be given to you at the appointment of the procedure.
5. Nitrous Oxide: If your child is very nervous about dental treatment, the dentist may decide to use Nitrous Oxide or "Laughing Gas" to help calm the child so dental treatment can be performed in the most comfortable way for your child.

After any dental treatment if your child complains of pain, Tylenol can be given to help. If you think that it is an emergency you can contact the program coordinator, at 303-439-5961 or 303-552-7884 or take your child to the emergency room. By signing this form you are consenting that your child may be treated by KIND dental staff. You are also confirming that you understand the dental treatment descriptions above and all your questions have been answered.

Patients Name: _____

Parent/Guardian Print: _____

Parent/Guardian Signature: _____Date: _____

Accompaniment Authorization Form

By signing this form, I acknowledge the following:

This authorization form enables a person other than myself to accompany my child to his or her dental appointment.

This form is NOT an authorization to perform dental treatment on my child. In order to perform dental services on my child, I must sign a consent form authorizing my child's treatment plan. This form DOES NOT allow the person accompanying my child to the dental appointment to consent to treatment.

I will discuss the following with the person who will be escorting my child to the appointment:

He or she must stay throughout my child's appointment.

In order to provide safe, adequate care for my child, I will provide a telephone number where to reach me should the dentist need consultation or in instances of emergency.

Services will need to be paid for at the time they are rendered.

I understand that the individual accompanying my child may have to make a decision concerning behavior modification or the use of nitrous oxide during my child's dental appointment.

I, _____, give _____,or _____, permission to

(Parent or Legal guardian) (Name of adult escort(s) (Name of adult escort(s)

accompany my child _____ to KIND dental clinic for clinical services.

(Child's name)

_____ Date: _____

(Signature of parent or legal guardian)

In case of Emergency Phone Number _____