Pediatric Dental Healthcare
Specialists in Pediatric Dentistry and Orthodontics

MEDICAL / DENTAL HISTORY UPDATE

(FOR THE SAFETY OF OUR PATIENTS, WE REQUIRE A MEDICAL HISTORY UPDATE EVERY 6 MONTHS)

Patient's Name_____Birthdate_____

Do you have any concerns/questions about the patient's dental health that we can answer today?
(e.g., pain, broken teeth, mouth sores, stained teeth, oral habits, etc.)

Has the patient vomited or had a fever in the last 24 to 48 hours? Please Circle: YES NO

Has the patient stayed home from school today for ANY reason other than their dental visit? Please Circle: YES NO
If yes, please explain:

Please list all Allergies:

In order to keep the patient's record up to date and accurate, please CHECK off any changes and explain below:

- ❑ Parent's Marital Status / Name
- ❑ Dental Insurance
- ❑ Hospitalization
- ❑ Financial Responsibility
- ❑ New Medical Diagnosis
- ❑ Mental / Emotional Issues
- ❑ Addresses / Phone Numbers
- ❑ Current Medications
- ❑ Behavioral Issue

In an effort to improve communications with our patients, Pediatric Dental Healthcare is now emailing and texting appointment reminders. If you are interested in being included in this service, please enter your information below. Be aware that the email address you provide may also be used to email you personal information (e.g., receipts, invoices, letters) relating to the patient's dental care. Your information is only used for communications with you and other dental professionals. However; it is important to understand that, although it is extremely rare, any electronic data has the potential of being compromised. We do NOT share or sell personal information.

Email Address: _____ Mobile Phone#: _____
(Please Print Clearly) (Your Phone Provider May Charge a Texting Fee)

INFORMED CONSENT FOR PARENTS/GUARDIANS ACCOMPANYING THE PATIENT

****Please cross out any treatment that you do not want performed****

I hereby authorize the dentists and staff at Pediatric Dental Healthcare to perform diagnostic aids including an **examination, x-rays,** when necessary, **cleaning and fluoride treatment** as the standard of care to properly diagnose and record any and all dental conditions. Due to the cost of PPE as a result of COVID-19, you will be incurring a $10.00 charge for your appointment.

I authorize my insurance company to pay Pediatric Dental Healthcare all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered; whether or not it is covered by my insurance, all broken appointment fees and all late payment service charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Pediatric Dental Healthcare. This consent is to remain in effect from the date indicated until cancelled in writing.

SIGNATURE RELATIONSHIP TO PATIENT DATE

No Food, Drink, Photography or Video Recordings in the clinical areas. Strollers are not allowed on the second floor.