ABOUT YOU

Today’s Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

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

First Middle Last

I prefer to be called: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_\_\_

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

City: \_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_) \_\_\_\_\_\_\_­­\_\_\_\_\_\_\_

Cell Phone: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other family members seen by us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­

Name of person who lives nearby we should notify in the event of an emergency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Phone: (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why have you come to the office today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is he/she currently in pain? \_\_\_\_Yes \_\_\_\_\_No

Previous Dentist/Hygienist: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DENTAL HISTORY

Has the child ever had a serious problem associated with any dental treatment?

\_\_\_Yes \_\_\_No

Child’s current dental health is?

\_\_\_Good \_\_\_ Fair \_\_\_Poor

Does the child’s gums bleed? \_\_\_Yes \_\_\_No

How many times a day does the child brush? \_\_\_\_\_\_

How many times a week does the child floss? \_\_\_\_\_\_\_

What type of water does your child drink?

\_\_\_City Water \_\_\_Well Water \_\_\_Bottled Water \_\_\_Filtered Water \_\_\_Nursery Water

Does the child take any fluoride supplements?

\_\_\_Yes \_\_\_No

Is fluoride toothpaste used? \_\_\_Yes \_\_\_No

Does the child suck on his/her thumb? \_\_\_Yes \_\_\_No

MEDICAL HISTORY

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any serious illnesses or operations? \_\_\_\_Yes \_\_\_\_No

Are you currently under a physician’s care?

\_\_\_Yes \_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use tobacco products? \_\_\_Yes \_\_\_No

How long? \_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_

Please list all medications being taken:

For Females:

Are you taking birth control pills? \_\_\_Yes \_\_\_No

Are you pregnant? \_\_\_Yes \_\_\_No

If “Yes,” what week? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you nursing? \_\_\_Yes \_\_\_No

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has the child had any history of, or conditions related to any of the following?

Yes No

\_\_\_ \_\_\_ Anemia

\_\_\_ \_\_\_ Artificial Valves/joints/etc.

\_\_\_ \_\_\_ Asthma

\_\_\_ \_\_\_ Arthritis

\_\_\_ \_\_\_ Autism/Asperger’s

\_\_\_ \_\_\_ Blood Transfusion

\_\_\_ \_\_\_ Cancer/Chemotherapy, explain\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Congenital Heart Defect

\_\_\_ \_\_\_ Diabetes, what type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ Difficulty Breathing

\_\_\_ \_\_\_ Drug/Alcohol Abuse

\_\_\_ \_\_\_ Epilepsy/Seizures

\_\_\_ \_\_\_ Fever Blisters/Cold Sores

\_\_\_ \_\_\_ Mitral Valve Prolapse

\_\_\_ \_\_\_ Heart Murmur

\_\_\_ \_\_\_ Hemophilia/Abnormal bleeding

\_\_\_ \_\_\_ Hepatitis, what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ HIV/AIDS

\_\_\_ \_\_\_ Immunizations

\_\_\_ \_\_\_ Sinus Problems

\_\_\_ \_\_\_ Ulcers/Colitis

\_\_\_ \_\_\_ Sexually transmitted disease

\_\_\_ \_\_\_ Tuberculosis

\_\_\_ \_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any serious medical problems the child has ever had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the patient allergic to any of the following?

Yes No

\_\_\_ \_\_\_ Aspirin

\_\_\_ \_\_\_ Codeine

\_\_\_ \_\_\_ Penicillin

\_\_\_ \_\_\_ Latex

\_\_\_ \_\_\_ Erythromycin

\_\_\_ \_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSENT FOR SERVICES

To the best of my knowledge, all the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the hygienist at the next appointment.

\_\_\_ I understand that I am being seen by a licensed Colorado Dental Hygienist. I understand it is recommended that I see a licensed Dentist for dental exams yearly and that I am responsible for obtaining those exams.

\_\_\_ I understand that White River Dental Hygiene, PLLC will have my radiographs viewed and evaluated by a licensed dentist.

\_\_\_ I understand that communication may be done via e-mail and that it may not be encrypted. (Appointments reminders, x-rays, treatment notes, etc.) **Things like social security number and account information will not be shared, unless with an insurance company, which is encrypted.**

\_\_\_ Payment is solely the responsibility of the patient or responsible party. We will gladly bill insurance as a service to you, but any nonpayment or partial payment is then the patient’s responsibility. Non-payment may result in turning over your account to a collections agency.

I have read the above conditions of treatment and payment and I agree to their content.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

Signature of patient, Date

Parent or guardian