



# THE CHILDREN'S DENTAL GROUP

**RETURNING PATIENTS**

Please fill out both sides of this form and make sure to sign and date each section.  
Information Forms must be filled out by new patients and once each year for existing patients.

DATE \_\_\_\_\_

## PATIENT INFORMATION

NAME \_\_\_\_\_ SEX - Male  Female

DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

ADDRESS \_\_\_\_\_ APT # \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_

EMERGENCY CONTACT (Please use a different number from those listed above.) \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

## MEDICAL HISTORY

NAME OF PHYSICIAN \_\_\_\_\_ PHYSICIAN'S PHONE NO. \_\_\_\_\_

IS PATIENT TAKING ANY MEDICATION: YES  NO  IF YES, WHAT: \_\_\_\_\_

IS PATIENT ALLERGIC TO ANY OF THE FOLLOWING:

AMOXICILLIN/PENICILLIN  LATEX  LOCAL ANESTHETICS  ASPIRIN  METAL

OTHER, SPECIFY: \_\_\_\_\_

HAS PATIENT EVER HAD A SERIOUS ILLNESS OR BEEN HOSPITALIZED: YES  NO

IF YES, EXPLAIN: \_\_\_\_\_

PLEASE CHECK ALL THE CONDITIONS THE PATIENT HAS NOW OR HAS EVER HAD:

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> AIDS                              | <input type="checkbox"/> Cancer               | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Leukemia            | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Cerebral Palsy       | <input type="checkbox"/> Fainting / Dizziness | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Thyroid Disease       |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Chemotherapy         | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Autism                            | <input type="checkbox"/> Cold Sores           | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Psychiatric Care    | <input type="checkbox"/> Tumors                |
| <input type="checkbox"/> Blood Disease                     | <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Hepatitis A, B, C    | <input type="checkbox"/> Seizures            | <input type="checkbox"/> Ulcers                |
| <input type="checkbox"/> Blood Disorder / Bleeding Problem | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Wheel Chair Dependent |
| <input type="checkbox"/> Blood Transfusion                 | <input type="checkbox"/> Downs Syndrome       | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Stent               | <input type="checkbox"/> Other                 |

If other, specify: \_\_\_\_\_

To the best of my knowledge, I have answered every question accurately. I will inform my dentist of any changes in the patient's health.



\_\_\_\_\_  
Parent / Legal Guardian

\_\_\_\_\_  
Date



**PERMISSION FOR DENTAL TREATMENT, LOCAL ANESTHESIA (NUMBING SHOT), AND NITROUS OXIDE (LAUGHING GAS)**

- I hereby authorize the dentist to treat the person under my care with the following dental procedure (if or when needed): prophylaxis (cleaning), routine x-rays, restorations (fillings), crowns, extractions, root canal, or any other treatment the dentist considers necessary.
- The dentist has or will explain to me the purpose of the procedure(s) and has also explained the benefits and risks of the treatment.
- I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment. I therefore consent to the performance of any additional treatment that the dentist may consider necessary.
- I consent to the use of local anesthetic, antibiotics, and analgesics and have been explained all potential risks. I understand that there is a slight risk involved with the use of local anesthesia or the use of any drug. These risks include allergic reaction, aspiration, pain, cardiac arrest, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.
- I consent to the use of nitrous oxide analgesia (laughing gas) and have been informed of the risks and benefits of its use. I have been given no assurances or guarantees as to outcome of the treatment. I realize that in spite of the possible complication, my proposed treatment is necessary and desired by me.
- I understand that it is vital that I give as accurate and complete a medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures. I confirm that I have fully understood all the information provided above.



Parent / Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions but, if you do agree, then you are bound to abide by such restrictions.



Parent / Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

**MISSED APPOINTMENT POLICY**

We strive to provide all of our patients with the best dental care possible in the most timely manner possible. We understand that appointments must be rescheduled occasionally for a variety of reasons. However, our goal is to fill all available time slots in order to attend to all of our patients without unnecessary delay.

**Please give our office 48 hours advance notice in the event that you need to cancel or reschedule your appointment.**

To cancel or reschedule an appointment, you must call our office at (203) 787-1176. If you do not reach the receptionist, please leave a detailed voice mail message.

As too many patients have missed their appointments without calling us to cancel or reschedule, we must enforce the following policy: **If any patient should miss two appointments without calling to cancel within the 48 hour period, that patient will no longer be treated by this office.**



Parent / Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_