

Children's Dental Health Clinic

Health History Survey

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

Physician's Name (Medical Doctor): \_\_\_\_\_ Telephone: \_\_\_\_\_

*Please circle the appropriate answer*

|     |   |     |    |                          |  |     |    |
|-----|---|-----|----|--------------------------|--|-----|----|
| 1.  | Does your child have a health problem?  | YES | NO | 10.                      | Has your child had abnormal bleeding associated with previous surgery, extractions or accidents?       | YES | NO |
| 2.  | Was your child a patient in a hospital?   | YES | NO | 11.                      | Does he/she bruise easily?   | YES | NO |
| 3.  | Date of last physical exam:   |     |    | 12.                      | Has he/she ever required a blood transfusion?  | YES | NO |
| 4.  | Is your child now under medical care?   | YES | NO | 13.                      | Does he/she have any blood disorders such as anemia, etc.?   | YES | NO |
| 5.  | Is your child taking medication now?  | YES | NO | 14.                      | Has he/she ever had surgery, x-ray or chemotherapy for a tumor, growth, or other condition?            | YES | NO |
| 6.  | Has your child ever had a serious illness or operation?   | YES | NO | 15.                      | Does your child have a disability that prevents treatment in a dental office?                          | YES | NO |
| 7.  | If so, explain:<br>Does your child have (or ever had) any of the following diseases?  |     |    | 16.                      | Is he/she taking any of the following?   |     |    |
| a.  | Rheumatic fever or rheumatic heart disease  | YES | NO | a.                       | Antibiotics or sulfa drugs   | YES | NO |
| b.  | Congenital heart disease  | YES | NO | b.                       | Anticoagulants (blood thinners)  | YES | NO |
| c.  | Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) | YES | NO | c.                       | Medicine for high blood pressure   | YES | NO |
| d.  | Allergy? Food <input type="checkbox"/> Medicine <input type="checkbox"/> Other <input type="checkbox"/>   | YES | NO | d.                       | Cortisone or steroids  | YES | NO |
| e.  | Asthma <input type="checkbox"/> Hay Fever <input type="checkbox"/>  | YES | NO | e.                       | Tranquilizers  | YES | NO |
| f.  | Hives or a skin rash  | YES | NO | f.                       | Aspirin  | YES | NO |
| g.  | Fainting spells or seizures   | YES | NO | g.                       | Dilantin or other anticonvulsant   | YES | NO |
| h.  | Hepatitis, jaundice or liver disease  | YES | NO | h.                       | Insulin, tolbutamide, Orinase, or similar drug   | YES | NO |
| i.  | Diabetes  | YES | NO | i.                       | Any other medications?   | YES | NO |
| j.  | Inflammatory rheumatism (painful or swollen joints)   | YES | NO |                          | What medications?  |     |    |
| k.  | Arthritis   | YES | NO | 17.                      | Is he/she allergic to, or has he/she ever reacted adversely to any of the following?                   |     |    |
| l.  | Stomach ulcers  | YES | NO | a.                       | Local anesthetics  | YES | NO |
| m.  | Kidney trouble  | YES | NO | b.                       | Penicillin or other antibiotics  | YES | NO |
| n.  | Tuberculosis (TB)   | YES | NO | c.                       | Sulfa Drugs  | YES | NO |
| o.  | Persistent cough or cough up blood  | YES | NO | d.                       | Barbiturates, sedatives, or sleeping pills   | YES | NO |
| p.  | Venereal Disease  | YES | NO | e.                       | Aspirin  | YES | NO |
| q.  | Epilepsy  | YES | NO | f.                       | Any other?   |     |    |
| r.  | Sickle Cell disease   | YES | NO | 18.                      | Has he/she had any serious trouble associated with any previous dental treatment?                      | YES | NO |
| s.  | Thyroid disease   | YES | NO |                          | If so, explain:  |     |    |
| t.  | AIDS/HIV  | YES | NO | 19.                      | Has your child been in any situation which could expose him/her to x-rays or other ionizing radiators? | YES | NO |
| u.  | Emphysema   | YES | NO | 20.                      | Last date of dental examination:   |     |    |
| v.  | Psychiatric treatment   | YES | NO | 21.                      | Has he/she ever had orthodontic treatment (worn braces)?   | YES | NO |
| w.  | Cleft lip / palate  | YES | NO | 22.                      | Has he/she ever been treated for any gum diseases (gingivitis, periodontitis, trenchmouth, pyorrhea)?  | YES | NO |
| x.  | Cerebral palsy  | YES | NO | 23.                      | Does his/her gums bleed when brushing teeth?   | YES | NO |
| y.  | Mental retardation  | YES | NO | 24.                      | Does he/she grind or clench teeth?   | YES | NO |
| z.  | Hearing disability  | YES | NO | 25.                      | Has he/she often had toothaches?   | YES | NO |
| aa. | Developmental disability  | YES | NO | 26.                      | Has he/she had frequent sores in his/her mouth?  | YES | NO |
|     | If yes, explain   |     |    | 27.                      | Has he/she had any injuries to his/her mouth or jaws?  | YES | NO |
| bb. | Was your child premature?   | YES | NO |                          | If yes, explain:   |     |    |
|     | If yes, how many weeks  |     |    | 28.                      | Does he/she have any sores or swellings of his/her mouth or jaws?                                      | YES | NO |
| cc. | Other:  |     |    | 29.                      | Have you been satisfied with your child's previous dental care?  | YES | NO |
| 8.  | Does your child have to urinate (pass water) more than six (6) times a day?   | YES | NO | <b>ADOLESCENT WOMEN:</b> |  |     |    |
| 9.  | Is your child thirsty much of the time?   | YES | NO | 30.                      | Are you pregnant now, or think you may be?   | YES | NO |
|     |   |     |    | 31.                      | Do you anticipate becoming pregnant?   | YES | NO |
|     |   |     |    | 32.                      | Are you taking oral contraceptives?  | YES | NO |

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or medication, I will inform the doctor at the next appointment without fail.

Parent/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_

# CHILDREN'S DENTAL HEALTH CLINIC FINANCIAL SCREENING

REFERRED BY \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ SEX: M F  
 BIRTHDATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_  
 ETHNIC GROUP: HISPANIC \_\_\_\_ WHITE \_\_\_\_ BLACK \_\_\_\_ ASIAN \_\_\_\_ OTHER (Specify) \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ APT. # \_\_\_\_\_  
 CITY: \_\_\_\_\_ ZIPCODE \_\_\_\_\_  
 HOME PHONE NUMBER: ( ) \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE NUMBER: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 E-MAIL ADDRESS \_\_\_\_\_  
 IN CASE OF EMERGENCY, CONTACT \_\_\_\_\_ PHONE # \_\_\_\_\_  
 HAS CHILD BEEN HERE BEFORE? NO \_\_\_\_ YES \_\_\_\_ WHEN? \_\_\_\_\_  
 DOES CHILD HAVE MEDI-CAL? NO \_\_\_\_ YES \_\_\_\_ CARD # \_\_\_\_\_  
 DO YOU HAVE DENTAL INSURANCE? NO \_\_\_\_ YES \_\_\_\_

**SOURCE OF INCOME:**

\_\_\_\_ EMPLOYED  
 \_\_\_\_ CHILD SUPPORT  
 \_\_\_\_ WELFARE  
 \_\_\_\_ UNEMPLOYMENT  
 \_\_\_\_ DISABILITY  
 \_\_\_\_ OTHER

**EXPENSES - MONTHLY (APPROXIMATE):**

|           |          |              |                   |
|-----------|----------|--------------|-------------------|
| RENT      | \$ _____ | GROCERIES    | \$ _____ (Weekly) |
| TELEPHONE | \$ _____ | CAR PAYMENT  | \$ _____          |
| GAS/WATER | \$ _____ | INSURANCE    | \$ _____          |
| LIGHTS    | \$ _____ | OTHER        | \$ _____          |
|           |          | <b>TOTAL</b> | <b>\$ _____</b>   |

HOW MANY PEOPLE ARE SUPPORTED BY YOUR INCOME? \_\_\_\_\_

When was your child's last dental visit? (approximately) \_\_\_\_/\_\_\_\_/\_\_\_\_

**EMPLOYMENT INFORMATION:**

**FATHER** EMPLOYER \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
 PAY PERIOD WEEKLY\_\_ BI-WEEKLY\_\_ SEMI-MONTHLY\_\_ MONTHLY\_\_ GROSS PAY \$ \_\_\_\_\_ NET PAY \$ \_\_\_\_\_

**MOTHER** EMPLOYER \_\_\_\_\_ PHONE ( ) \_\_\_\_\_  
 PAY PERIOD WEEKLY\_\_ BI-WEEKLY\_\_ SEMI-MONTHLY\_\_ MONTHLY\_\_ GROSS PAY \$ \_\_\_\_\_ NET PAY \$ \_\_\_\_\_

I certify that I have answered these questions accurately and truthfully to the best of my knowledge.

(PRINT) NAME OF PERSON FILLING OUT FORMS \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

\_\_\_\_\_  
 SIGNATURE OF MOTHER/FATHER OR LEGAL GUARDIAN DATE

I understand I am responsible to pay any balance not covered by insurance. My sliding scale rate is determined to be \_\_\_\_\_% off the usual and customary rate (UCR) per procedure. I understand payment is due the day service is rendered. If I am unable to keep my appointment, I will call to re-schedule at least one day in advance. Failure to show up for a scheduled appointment may result in a \$25.00 broken appointment fee. The Children's Dental Health Clinic does not carry over balances or offer credit.

\_\_\_\_\_  
 SIGNATURE OF RESPONSIBLE PERSON DATE

**OFFICE USE ONLY**

\_\_\_\_\_  
 WITNESS SIGNATURE DATE

To find monthly income amount: \$ \_\_\_\_\_  
 (check which method used)

- Weekly pay period – multiply net pay by 4.3
- Bi-weekly pay period – multiply net pay by 2.17
- Semi-monthly pay period – multiply net pay by 2
- Tax returns – total amount divided by 12

Dear Parent:

We are happy to see your children under your Insurance Program. However, we do have explicit office policies that we ask you to follow:

1. Please bring in a current Insurance Program Identification card and a picture I.D. for both parent and patient.
2. Please call us 24 hours in advance to cancel or change any appointments so you are not charged for a broken appointment.
3. Please be on time. Arriving late will be considered a broken appointment, and you may be charged a broken appointment fee.
4. You will be responsible for any procedure fee not covered by your insurance program.
5. Please make sure anyone bringing the patient is the legal parent or has legal guardianship papers from the court or a notarized letter from the parent giving authorization for dental treatment.

Thank you for your cooperation.

CHILDREN'S DENTAL HEALTH CLINIC

Signature \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Clinic Witness \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

APPLICATION FOR TREATMENT

Patient Name: \_\_\_\_\_  
Last First Middle

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

Name of Child's Previous Dentist (if any) : \_\_\_\_\_

Address: \_\_\_\_\_  
Street City Zip Code

Name of Guardian: \_\_\_\_\_

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

In case of emergency, contact \_\_\_\_\_

Phone # \_\_\_\_\_

**Agreement for Treatment**

1. Complete cooperation between the patient, the parent/guardian, the doctor is essential for successful dental treatment.
2. The Children's Dental Health Clinic office hours are Monday thru Friday 7:30 a.m. to 11:00 a.m. and 12:00 to 3:30 p.m. If post operative complications or a dental emergency arise after 3:30 p.m. or on weekends, you may contact the dentist on call at emergency department of Memorial Medical Center of L.B. Further, should you decide to visit said hospital, you may expect to be charged a substantial fee for which you will be personally responsible.
3. I understand that:
  - a. I am expected to pay for my child's dental treatment on the day of the visit. If the amount due were allowed to build up it would be difficult to pay. If I am unable to pay for a particular visit I will discuss this with the Receptionist before my child sees the dentist. NO CHECKS ACCEPTED.
  - b. That I will pay cash or with money order, no personal checks.
  - c. That the Clinic provides a program of dental education to teach the proper manner of caring for the teeth and gums and my child is required to attend this valuable Dental Education Program, for which there is no fee.

- d. That when the Clinic has completed the dental treatment on my child I will encourage that he/she makes an effort to keep his teeth clean, and make an appointment in 6 months for re-examination.
4. I hereby authorize the Children's Dental Health Clinic to use pictures taken of my child during treatment. It is understood and agreed that my child's name will not be used or in any way disclosed in connection therewith.
  5. I grant permission to the Children's Dental Health Clinic faculty to expose any necessary x-rays, administer anesthetics, to remove any tissue and/or structure and to employ such operative and technical procedures as are necessary or advisable for the diagnostic and restorative treatment of my child.
  6. I hereby consent to the use of behavior management techniques during the treatment of my child. These techniques represent the standard of pediatric dental care and include the use of voice control, hand-over-mouth technique, or soft restraint. It is understood that these techniques are needed only on a small percentage of patients, are not utilized in a punishing or threatening manner and are used to accomplish the gentlest and most productive treatment for your child.
  7. I will immediately report any change in my child's health, if he/she has been hospitalized, consulted a physician, been sick or has taken or is taking a new drug or medication in addition to those already reported on the medical history. And also any change in address, income or in number members in family.
  8. Patient with medical or dental insurance are responsible to pay dental treatment that has been billed to insurance office and has been denied for payment.

The undersigned certifies that he/she has read and is willing to comply with the foregoing and is the parent or guardian of the patient.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian



Patient's Name: \_\_\_\_\_

Birth Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### POLICIES & REGULATIONS

**As part of our goal to provide excellent service to you and your family, it is our responsibility to inform you of any changes regarding your child's dental treatment, appointment changes, and/or any information that may be needed prior to your child's dental visit.**

To ensure that parents are aware and understand clinic **Policies & Regulations**, we ask that you read carefully and initial the following:

- \_\_\_ Parent/Legal guardian must be present at all times while their child is receiving dental services. Patients without a parent/legal guardian present will not be seen and will be charged a broken appointment fee.
- \_\_\_ The Clinic must be notified 24 hours in advance if you need to cancel or re-schedule an appointment to avoid being charged a broken appointment fee.
- \_\_\_ After the 3<sup>rd</sup> missed appointment, you are no longer eligible to be seen here and will be referred out. The clinic staff will call as a courtesy to remind you of your appointment, but it is the parent's responsibility to remember the date and time of their child's appointment.
- \_\_\_ Vaccination records must be provided with up-dated Tb (Tuberculosis test results) within the last 5 years. The clinic staff is not obligated to call the medical office/school to obtain medical records.
- \_\_\_ Patients with a Positive Tb skin result must provide a negative chest x-ray result/symptom review form within the last 5 years indicating that the patient is free of any Tb (Tuberculosis) symptoms.
- \_\_\_ If you are late 15 minutes or more, you can potentially lose the time reserved for your child to be seen. This will be considered a broken appointment.
- \_\_\_ Patients with Medi-Cal must present a current insurance card in order to obtain valid eligibility. Insurance cards with an invalid subscriber ID or no recorded eligibility will be treated as cash patients and will be charged based on a sliding fee schedule.
- \_\_\_ If you have a balance pending on your child's account, no further appointments will be given until balance is paid in full. Payment must be obtained on the date of service or in advance.

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

\_\_\_\_\_  
Date