Children's Dental Health Clinic **Medical & Dental History**

Child's Name: ____ Date of Birth: ____________________ Age: ______

Address: ____ Zip: ________ Telephone: ____________________

In case of Emergency, contact: ____Telephone: ____________________

Physician's Name (Medical Doctor): _______________________________________Telephone: ____________________

Has your child had any history of, or conditions related to, any of the following (check if yes)

☐ Autism	☐ Asthma	☐ Hives or a skin rash
☐ Psychiatric treatment	☐ Lung Disease	☐ Arthritis
☐ Anxiety/Depression	☐ Tuberculosis (TB)	☐ Stomach problems/ulcers
☐ Down Syndrome	☐ Rheumatic Fever	☐ Pregnancy
☐ Cerebral Palsy	☐ Heart disease/surgery	☐ Premature birth? # of weeks ____
☐ Fainting spells or seizures	☐ Heart murmur	☐ Sexually Transmitted Disease
☐ Epilepsy	☐ Blood disorder	☐ Hepatitis, jaundice or liver disease
☐ Intellectual/developmental disability	☐ Sickle cell disease	☐ Diabetes
☐ Cleft lip or palate	☐ Kidney Disease	☐ Thyroid disease
☐ Spina Bifida	☐ HIV/AIDS	☐ Hypertension/high blood pressure
☐ Hearing Problems	☐ Childhood cancer/tumors	☐ Other_____________________
☐ Vision Impaired	☐ COVID-19	

	Yes	No
1. Is your child taking any prescription or over the counter medications at this time?..........................	☐	☐
If yes, please list: ____		
2. Is she taking oral contraceptives?..	☐	☐
3. Is your child allergic to any medications?...	☐	☐
If yes, please list: ____		
what happens? ____		
4. Does your child have any food, seasonal or other allergies? Latex Products?	☐	☐
If yes, please list: ____		
what happens? ____		
5. Has your child ever been hospitalized or had a serious illness or operation?	☐	☐
If yes, When & Why: ____		
6. Has your child had abnormal bleeding associated with previous surgery, extractions or accidents?	☐	☐
7. Has he/she ever required a blood transfusion?...	☐	☐
8. Has your child had chemotherapy or radiation therapy?	☐	☐
9. Does your child have a disability that may affect treatment in a dental office?	☐	☐
If yes, please explain: ____		
10. Is this the child's first visit to a dentist?	☐	☐
If not the first visit, what was the date of the last dentist visit? ______________________________		
11. Has your child had any problem with past dental treatments?	☐	☐
If yes, What & When: ____		
12. Has he/she ever had orthodontic (braces) treatment?	☐	☐
13. Has he/she ever had injuries to his/her mouth or jaws?	☐	☐
14. Does he/she have any pain, sores or swelling of his/her mouth or jaws?......................................	☐	☐

WHAT IS THE REASON FOR THE VISIT TODAY? ____

____

To the best of my knowledge, all of the above 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 _________________

Print Name _______________________________________ Relationship ________________

Patient Name: ____
Last First Middle

Patient's Date of Birth: ____________________

Name of Guardian: ____

Relationship: ______________________ Telephone ________________________

In case of emergency, contact ____________________________ ____________________
Phone #

POLICIES AND TREATMENT AGREEMENT

Please read and initial the following policies:

____ Parent/Legal guardian must be present for the initial visit and recall visit and cannot leave the waiting area while child is being treated. Patients without a parent/legal guardian present, or without a signed form assigning authorization will not be seen.

____ It is my responsibility to bring my child to the Clinic at the date and time of his/her appointment. I must notify the Clinic at least 24 hours in advance if I need to cancel or re-schedule an appointment in order to avoid being charged a broken appointment fee.

____ If you have Denti-Cal a missed or broken appointment can be reported to Medi-Cal.

____ If I am late, or do not confirm my appointment I can potentially lose the time reserved for my child to be seen or have my appointment cancelled. This will be considered a broken appointment.

____ After a 3rd missed appointment, I might become ineligible to have my child seen at the Clinic.

____ I will immediately report any health or medication changes to what has already been reported on my child's medical history form as well as any changes to the information previously provided to the Clinic, such as address, income or number of members in my family.

____ The Children's Dental Health Clinic accepts Medi-Cal and some PPO insurances. For low-income families without insurance, we have sliding scale fees when providing proof income.

____ Patients with Medi-Cal must present their current insurance card in order to prove valid eligibility.

____ I understand I am responsible to pay for any dental treatment that is not covered or is denied by insurance. I am expected to pay on the day of the visit.

____ I grant permission to the Children's Dental Health Clinic to take any x-rays and/or perform dental prophylaxis necessary or advisable for my child's diagnostic and restorative treatment.

____ I hereby consent to the use of appropriate behavior guidance techniques during my child's treatment.

____ I hereby authorize the Children's Dental Health Clinic to use pictures/videotape taken of my child during treatment for brochures or other printed materials, website, or other ways that are needed by the CDHC. I understand that my child will not be identified by name.

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

CHILDREN'S DENTAL HEALTH CLINIC
FINANCIAL SCREENING and AFFIDAVIT OF INCOME

How did you hear about our Clinic? ____________________ ***Sex: Male*** ☐ ***Female*** ☐

Patient Name: ______________________________

Birthdate: ____/____/____ Age _____ Social Security # ____________________

Address: ______________________________ Apt. # ________

City: ____________________ Zip Code: __________

Home Phone Number: ( ) ______ - ________ Cell Phone Number: ( ) ______ - ________

E-Mail Address: ______________________________

Has child been treated here before? NO ____ YES ____ If yes, when? ____________

Does child have Medi-Cal? NO ____ YES ____ Card # ____________________

Do you have dental insurance? NO ____ YES ____

List all household members		Age	Check all that Apply	Relationship to Head of Household	Annual Income Check all that Apply
Head of Household			☐Disabled ☐Senior	☐Female ☐Male	$________ ☐Other________ ☐Employed ☐Retired ☐Unemployed
Name of Member 2			☐Disabled ☐Senior		$________ ☐Other________ ☐Employed ☐Retired ☐Unemployed
Name of Member 3			☐Disabled ☐Senior		$________ ☐Other________ ☐Employed ☐Retired ☐Unemployed
Name of Member 4			☐Disabled ☐Senior		$________ ☐Other________ ☐Employed ☐Retired ☐Unemployed
Name of Member 5			☐Disabled ☐Senior		$________ ☐Other________ ☐Employed ☐Retired ☐Unemployed
Name of Member 6			☐Disabled ☐Senior		$________ ☐Other________ ☐Employed ☐Retired ☐Unemployed
Name of Member 7			☐Disabled ☐Senior		$________ ☐Other________ ☐Employed ☐Retired ☐Unemployed
Name of Member 8			☐Disabled ☐Senior		$________ ☐Other________ ☐Employed ☐Retired ☐Unemployed

Family Size __________

1. Ethnic Background (Check One): ☐Hispanic ☐No-Hispanic
2. Racial Background (Check One):

	White		American Indian / Alaskan Native & White
	Black / African American		American Indian / Alaskan Native & Black
	Asian		Asian & White
	American Indian / Alaskan Native		Black & White
	Native Hawaiian / Pacific Islander		Other Multi-Racial

I understand I am responsible to pay any dental treatment that is not covered or is denied by insurance. My sliding scale rate is determined to be ________% of the usual and customary rate (UCR) per procedure. I understand payment is due the day service is rendered. The Children's Dental Health Clinic does not offer credit. If I am unable to keep my appointment, I will call to re-schedule at least one day in advance. Failure to do so may result in a broken appointment fee.

(PRINT) Name of person filling out forms: ______________________________
Relationship to Patient: ______________________________

According to Title 18 , Section 1001 of the U.S. Code, it is a felony for any person to knowingly and willingly make a false or fraudulent statements to any department of the United States Government. I, the undersigned, hereby certify that all statements contained herein, are true and correct to the best of my knowledge and belief. I understand the information I provide in certification is subject to verification, and agree to provide necessary documentation if requested to do so.

Under the penalty of perjury, I certify that the above information is true and correct

______________________________ Applicant Signature

______________ Date

OFFICE USE ONLY

______________________________ WITNESS SIGNATURE

_____/_____/_____ DATE

TOTAL FAMILY INCOME (MONTHLY) __________

HUD Pov. Level ☐ EXT-LW ☐ VL ☐L