

Kellye N. Rice, D.M.D., P.L.L.C.
Cosmetic & Family Dentistry

CONFIDENTIAL DENTAL AND MEDICAL HISTORY

[Please print]

Personal History for a child *under the age of 18* to be completed by parent or guardian.

Date: _____ Home Phone: _____

Patient's Name: _____
LAST FIRST MIDDLE INITIAL PREFERRED NAME

Home Address: _____
STREET CITY STATE ZIP

Sex: M F Age: _____ Birth Date: _____

Who is responsible for this account: _____

Relationship to Patient: _____

Social Security # of responsible party: _____

Home Address: _____
STREET CITY STATE ZIP

Phone (home): _____ (Work) _____ (Cell) _____

Employer: _____

INSURANCE INFORMATION

Is this child covered by dental insurance? Yes No

If yes, please complete *Insurance Information* form.

How will you be paying for today's visit? Check Cash Credit Card (MC/Visa only)

In case of emergency, call _____	Relationship to patient _____	Phone _____
How did you find out about our dental office?		
<input type="checkbox"/> Referred by _____		
<input type="checkbox"/> Other (please specify) _____		

FINANCIAL POLICY

You have been given a copy of our *Financial Policy* which describes payment requirements, insurance filing, appointment prepayments, and unpaid balances. Please read and sign that form.

I am interested in a payment plan. I would like more information. Yes No

(Please continue on the back of this form) ↗

Dental History - Child

Reason for this visit: _____ Date of last dental visit _____

Has this child ever had any of the following: (circle Yes or No)

Bleeding gums	Yes	No	Gag easily	Yes	No
Food impaction	Yes	No	Complications from extractions	Yes	No
Burning Tongue	Yes	No	Gum treatments	Yes	No
Swelling in mouth	Yes	No	Teeth straightened	Yes	No
Lump in mouth	Yes	No	Mouth breathing	Yes	No
Lip or mouth blisters	Yes	No	Pipe, cigar, cigarette smoking	Yes	No
Clenching teeth	Yes	No	Cheek, lip, fingernail biting	Yes	No
Grinding of teeth	Yes	No	Major dental treatment	Yes	No
Bad breath	Yes	No	Unusual sounds in ear when chewing	Yes	No
Unpleasant taste	Yes	No	Loose teeth	Yes	No
Tired jaws	Yes	No	Chew on only one side of mouth	Yes	No
Many cavities	Yes	No	Snore	Yes	No
Loose or broken fillings	Yes	No	Sleep apnea	Yes	No

Medical History

Physician's Name _____ Date of Last Physical: _____

Has this child ever had any of the following? (check boxes that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ever taken Fen-Phen |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hepatitis, jaundice, liver disease | <input type="checkbox"/> Special diet |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Swollen neck glands |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Chronic diarrhea | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Allergies to anesthetics | <input type="checkbox"/> AIDS or other immunosuppressive disorder |
| <input type="checkbox"/> Artificial heart valves or joints | <input type="checkbox"/> Allergies to medicine or drugs | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Recent weight loss | <input type="checkbox"/> General allergies | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Blood disease | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chemical dependency |
| <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Lasik or other eye surgery: | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Epilepsy | Date: _____ | |

Does this child have allergies or adverse reactions to any medication? ____ If so, what? _____

Has this child ever taken the drug Fosamax? _____ If so, when? _____ By IV, or orally? _____

Is this child taking any medications at this time? _____ If so, what? _____

Is this child under the care of a physician? _____ For what conditions: _____

What is the estimated weight of the child? _____

List all surgeries and their dates: _____

Is there anything else we should know about this child's medical history: _____

The information provided on this form is accurate and complete to the best of my knowledge and is only for use in this child's treatment, billing, and processing of insurance for benefits for which I am entitled. I will not hold Dr. Rice or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form. I understand that at my child's initial visit xrays will be taken, and a fluoride treatment will be given routinely after his/her teeth are cleaned and polished. As a standard of care, subsequent checkup xrays are taken once a year, and a Panorex xray by age 6, then every 5 years to follow growth and development. I also understand that I must be present at my child's initial visit and when any treatment is being performed.

Signature of Parent or Guardian: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of the Notice of Privacy Practices for Kellye N. Rice, D.M.D., P.L.L.C. has been made available to me. I am signing this form on behalf of myself and any of my dependents under the age of 18 who are, or will become, patients in this office.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (please specify)

