Dental Associates of Connecticut
Where our family cares for yours
SINCE 1971

For Our Young Patients

Please complete as thoroughly as possible. At Dental Associates of Connecticut, we're interested in developing a complete dental health program for your family. In order to do this, we must know as much about the individual as we do about their teeth and tissue around them. No two people are the same & no two mouths are alike! Be assured that all the information you give is kept in strict confidence and in accordance with US government privacy regulations. ***Thank you.***

Date: _____

Patient Name: _____ Date of Birth: _____/_____/_____ ❒ Male ❒ Female
Last *First* *Middle*

Home Street Address: _____/ Mailing Address: _____

City, State & Zip Code: _____ Home Phone: _____

Patient's Current School: _____ Current Grade: _____

PARENT/GUARDIAN INFORMATION:

Parent Marital Status: ❒ Married ❒ Divorced ❒ Separated ❒ Other

Parent 1 Name: _____ ❒ Mother ❒ Father ❒ Guardian ❒ Other
(Please check appropriate box)

Date of Birth: _____/_____/_____ Social Security #: _____- _____- _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Position: _____ How Long? _____

Business Address: _____ Business Phone #: _____

Parent 2 Name: _____ ❒ Mother ❒ Father ❒ Guardian ❒ Other
(Please check appropriate box)

Date of Birth: _____/_____/_____ Social Security #: _____- _____- _____

Home Phone #: _____ Cell Phone #: _____

Employer: _____ Position: _____ How Long? _____

Business Address: _____ Business Phone #: _____

How would you prefer we confirm your child's appointments? ❒ Home ❒ Cell ❒ Work ❒ Text/ Email

- ❖ For email reminders, please provide an email address: _____

Name(s) & age(s) of other children living at home: _____

How did you hear about us?

❒ A family member or friend is a patient here. Who may we thank for this referral? _____

❒ Newspaper/Magazine ❒ Television ❒ Radio ❒ Sign on Building ❒ Direct Mail

❒ Community Event (please specify) _____

❒ Internet Search _____ ❒ Other _____
(please specify – i.e. Google, Yahoo!, Invisalign website, insurance website, etc) (please specify)

DENTAL INSURANCE INFORMATION:

Dental Insurance Company: _____ Group Number: _____

Policy Holders Name: _____ ID Number: _____

Please note: an ID number or Social Security number is required to submit insurance claims

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MEDICAL HISTORY:

Last physical exam was on (date): _____/_____/_____ Name of Pediatrician: _____

Has your child ever been hospitalized? If so, when/why? ..... ❒Yes ❒No

Has your child ever been treated in an emergency room? If so, when/why?..... ❒Yes ❒No

Does your child have any history of using any tobacco products? ..... ❒ Yes ❒No

Is there a chance that your child could be pregnant?..... ❒Yes ❒No

Has your child ever had an unfavorable reaction to any medication? If so, explain: ..... ❒Yes ❒No

Were there any problems at birth? ..... ❒Yes ❒No

If so, please explain: _____

Please check if your child has, or has had any of the following:

❒ AIDS/HIV
❒ Anemia
❒ Arthritis
❒ Asthma
❒ Bleeding Problems
❒ Breathing Problems
❒ Bruise Easily
❒ Cancer/Chemo/Radiation
❒ Cleft Lip/Palate
❒ Developmental Disability
❒ Diabetes
❒ Drug Addiction
❒ G.I./Reflux
❒ Hearing problems
❒ Heart Disease/Defects
❒ Heart Murmur
❒ Hepatitis/ Liver Problems
❒ Kidney Disease
❒ Psychiatric Issues
❒ Rheumatic Fever
❒ Seizures
❒ Sickle Cell Anemia
❒ Speech problems
❒ Thyroid (Hyper/Hypo)
❒ Tuberculosis
❒ Other: _____

Allergies – Is your child allergic to, or has/had an adverse reaction to any of the following:

❒ Antibiotics (any)
❒ Novocain/Epinephrine
❒ Food Allergies: _____
❒ Jewelry/Metals
❒ LATEX
❒ Other: _____

If you said **yes** to *any* of the above, or if your child has any disease, condition, problem or concern not listed, please explain: _____

_____

_____

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Drugs and Medications - Please specify the drug name/dosage of any daily medications:

Antibiotics: _____
Anticonvulsant drugs: _____
Antihistamines: _____
Birth control (if applicable): _____
EPI PEN (for): _____
Insulin/ diabetes medications: _____
Mood altering drugs: _____
Sedatives: _____
Steroids: _____
Thyroid medications: _____
Vitamins/supplements: _____
Other medication not listed: _____

DENTAL HISTORY:

Has your child had any problems with previous dental treatment? ……❒Yes ❒No
Has your child recently injured their mouth or jaws? ……❒Yes ❒No
Does your home have fluoridated water? ……❒Yes ❒No
Do you give your child fluoride supplements? ……❒Yes ❒No
Does your child have any finger, thumb, and/or pacifier habits?……❒Yes ❒No
Is your child a "mouth breather"?……❒Yes ❒No
What are your child's current hobbies/interests? _____

_____

Consent:

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the child's dental needs. Additionally, this document authorizes the doctor to perform all recommended treatment mutually agreed upon by parent of child, and to use the appropriate medication and therapy indicated for such treatment in connection with the child. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide the recommended treatment. This authorization will remain in effect until further notice, or until personally revoked by me (parent/guardian).

To the best of my knowledge, the above information is complete and accurate. I understand that even though I may have some type of insurance coverage, I am responsible for payment for services rendered for my child/children. If deemed necessary by Dental Associates, my credit may be checked. I authorize release of any information to my insurance company relating to my dental claims.

GUARDIAN'S SIGNATURE _____ DATE _____

SUMMARY/NOTES: _____

_____

DOCTOR'S SIGNATURE _____ DATE _____

Please See Other Side for HIPAA Acknowledgement and Consent

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Patient Name: _____ Date of Birth: _____

Acknowledge of Receipt of Notice of Privacy Practices and Consent

By signing below, I acknowledge that I have been provided a copy of the Dental Associates of Connecticut, PC Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this Notice, and how I may obtain access to and control this information.

By signing below, I also consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment of services given to me, and for the business operations of medical group, its staff, and its business associates.

I grant permission for Dental Associates of Connecticut to disclose my personal health information, including appointment times, treatment plans and financial information, to the following person(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

❒ I do not grant permission to disclose my information to any personal representative(s)

I understand that this permission will remain in effect unless a written cancellation has been provided to Dental Associates of Connecticut.

_____
Signature of Patient or Personal Representative

_____
Print Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority