Talwar FAMILY DENTISTRY

Confidential Health History & Registration
Child

Patient Name _____ Date of Birth_____ SSN# _____

Home Phone _____ Person Financially Responsible _____

Home Address (Street, City, Zip) _____

Guardian Name _____ Relationship to patient _____

Guardian Phone # _____ SSN# _____ Email _____

Guardian Name _____ Relationship to patient _____

Guardian Phone # _____ SSN# _____ Email _____

Will someone other than a legal guardian accompany patient to appointments? **(Yes / No)**

How did you hear about us? _____

I. MEDICAL HISTORY

1. Yes / No Has child gone to the hospital or emergency room or had a serious illness in the last three years?
2. Yes / No Is child being treated by a physician now? Physician name: _____
   Date of last medical exam: _____ Reason for exam: _____
3. Yes / No Has child ever taken bisphosphonate medications (Eg. Fosamax)?
4. Yes / No Does child have allergies to medications, latex, or metal?

If YES to any question, explain: _____

5. Yes / No Is there any issue or condition that you would like to discuss with the dentist in private?
6. Yes / No Is child currently taking any medications? List: _____

II. HAS YOUR CHILD EVER HAD OR HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

Yes / No Heart disease	Yes / No AIDS/HIV	Yes / No Psychiatric care
Yes / No Surgeries	Yes / No Heart attack	Yes / No Hospitalization
Yes / No Thyroid disease	Yes / No Artificial joint	Yes / No Diabetes
Yes / No Asthma	Yes / No Stomach problems or ulcers	Yes / No Family history of diabetes
Yes / No Hepatitis	Yes / No Heart defects	Yes / No Tumors or cancer
Yes / No Sexual transmitted disease	Yes / No Heart murmurs	Yes / No Chemotherapy
Yes / No Herpes	Yes / No Rheumatic fever	Yes / No Radiation
Yes / No Canker or cold sores	Yes / No Skin disease	Yes / No Arthritis, rheumatism
Yes / No Anemia	Yes / No Emphysema/other lung disease	Yes / No Liver disease
Yes / No High blood pressure	Yes / No Kidney or bladder disease	Yes / No Eye disease
Yes / No Seizures	Yes / No Stroke	Yes / No Transplants
Yes / No Eating disorders	Yes / No Tuberculosis	Yes / No Acid Reflux

Other: _____

III. FEMALE ONLY (Please circle Yes or No for each)

Yes / No Is/could your child be pregnant? If YES, what month of pregnancy? _____

Yes / No Is she nursing? Yes / No Is she taking birth control pills?

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in my child's health and/or medication. Further, I will not hold the dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Parent Name _____ **Date** _____

Parent Signature _____ **Dentist Signature** _____

Talwar
FAMILY DENTISTRY

Dental History
Child

Patient Name _____ Date of Birth_____

Date of last dental visit _____ Reason for last visit _____

Previous Dentist _____

If you left your previous dentist, what was the reason? _____

What is the reason for your visit today? _____

Has your child:		If Yes, explain:
1. Complained about any dental problems or pain?	**Yes/No**	_____
2. Had any unhappy dental experiences?	**Yes/No**	_____
3. Had any injuries to mouth, teeth or head?	**Yes/No**	_____
4. Lost any teeth from trauma?	**Yes/No**	_____
5. Had any missing teeth replaced?	**Yes/No**	_____
6. Had orthodontic treatment either now or in the past?	**Yes/No**	_____
7. Ever been premedicated for dental treatment?	**Yes/No**	
Does your child:		**If Yes, explain:**
8. Have any mouth habits such as thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier use, etc?	**Yes/No**	_____
9. Have any unusual speech habits?	**Yes/No**	_____
10. Brush his/her teeth daily?	**Yes/No**	How many times a day?_____
11. Receive help from a parent when brushing?	**Yes/No**	
12. Use an electric toothbrush?	**Yes/No**	
13. Use a fluoride toothpaste?	**Yes/No**	
14. Floss his/her teeth regularly?	**Yes/No**	
15. Grind his/her teeth?	**Yes/No**	
16. Want or need orthodontic treatment?	**Yes/No**	If Yes, why?:_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that the dentist and his/her staff will rely on this information for treating my child. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Parent Name _____ Date _____

Parent Signature _____

Dentist Signature _____

Talwar
FAMILY DENTISTRY

Parent/Patient Responsibilities

We are committed to providing you with the best possible care and helping you achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

Payment

Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, Credit (Visa, Mastercard, Discover, American Express), Debit, and CareCredit. * Please note: If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

Scheduling of Appointments

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, *we do require 2 business days to reschedule an appointment*. With less than 2 business days notice, a fee of ***$30*** or a deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to apply the fee and reschedule an appointment if a patient is ***15 minutes late*** or more arriving to our practice. **Initial_____**

Parent/Patient Authorizations and Acknowledgements

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services for my child that I have consented to during diagnosis and treatment.

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.

I hereby acknowledge that a copy of this practice's *Notice of Privacy Practices* has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I hereby acknowledge that a copy of this practice's *Dental Materials Fact Sheet* has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

Patient Name _____

Parent Name _____

Parent Signature _____ Date: _____