

Medical History

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

	Yes	No		Yes	No		Yes	No
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mental disabilities	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/ HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	Physical disabilities	<input type="checkbox"/>	<input type="checkbox"/>
Allergies/Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric problems	<input type="checkbox"/>	<input type="checkbox"/>
Autism	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Shunts	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Type_____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>						

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Was your child full term? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Did your child have any difficulty after birth or any serious illnesses the first year of life? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is your child being treated by a physician at this time?
If yes, why? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is your child taking any medication/vitamins at this time?
If yes, what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has your child ever been hospitalized?
If yes, explain. _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is your child allergic to anything? (medicine/food)
If yes, what? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does your child have problems in: <input type="checkbox"/> concentrating <input type="checkbox"/> learning <input type="checkbox"/> cooperating <input type="checkbox"/> understanding | | |
| 8. Name of child's physician: _____ Physician's phone #: _____

Date of last visit: _____ Immunizations up to date? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 9. How would you rate your child's attitude toward medical / dental visits?
<input type="checkbox"/> positive <input type="checkbox"/> anxious <input type="checkbox"/> definitely negative | | |
| 10. Is there anything else we should know about your child? _____

_____ | | |

Staff comments: _____

Dental History

1. Is this your child's first dental visit? Yes No
If no, give date of last examination: _____ Dentist name: _____
2. Has your child ever had any of the following? Please check.
 abscesses toothaches cold sores ulcers
 bad breath injury to front teeth grinding
3. Does your child have any habits or a history of a habit?
Pacifier Yes No Age discontinued _____
Finger / thumb Yes No Age discontinued _____
4. Is there a history of dental decay or missing teeth in the family?
 Yes No If yes, Explain: _____
5. Are your child's teeth brushed once or more a day by an adult? Yes No ; Floss? Yes No
6. What dental concerns do you have about your child? _____

7. If your child is under the age of 6, when did first baby tooth erupt? _____

Diet History

1. Did or Do you breast feed your child? Yes No
What age did you discontinue breastfeeding? _____
2. Did or Do you bottle feed your child? Yes No
What age did you discontinue bottle-feeding? _____
3. What foods does your child like for a snack? _____
4. What does your child drink on a daily basis? _____

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Rozas and her dental staff to take x-rays, models, photographs and other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I give Dr. Rozas and her staff permission to send records or x-rays to another facility/doctor in case of emergency. This consent shall remain in full force and effect until canceled by either party.

Signature of parent or guardian

Relationship to patient

Date

Melissa V. Rozas, D.D.S., P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your office of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the rights to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name

Relationship to Patient

Signature

Date

For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify):