Pediatric Dentistry of Pittsburgh

Ryan Shaw, DMD
Board Certified Pediatric Dentist

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1600 Pacific Avenue, Natrona Heights, PA 15065
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Child's Name_____Nickname_____

Date of Birth_____Male_____Female_____Weight_____Today's Date_____School_____

Father's Name_____ Name and Complete Address of Nearest Relative Not Living With You:

Mother's Name_____ _____

Home Address_____ _____

_____ _____

Home Phone_____Relationship To Relative_____

Referred By:_____Home Phone_____

Medical History

1. Child's Physician or Group Practice_____Physician's Phone # _____
2. Place of Birth_____
3. Any problems or medications during pregnancy?_____
4. Is your child in good health now?_____
5. Taking any medications?_____If so, what drug (s) and for what reason?_____

_____

6. Names and ages of siblings:_____
7. Has your child ever had any of the following:

Heart disease or defects_____Autism/ADHD_____Sight Problems_____
Heart Murmur_____Asthma/Breathing Difficulties_____Emotional Problems_____
Rheumatic Fever_____Anemia or Blood Disorders_____Cleft Lip or Palate_____
Diabetes_____Bleeding Difficulties_____Mental Retardation_____
Kidney Disease_____Hepatitis or Liver Disease_____Cerebral Palsy_____
Convulsions_____Dizziness or Fainting_____Birth Defects_____
Latex Allergies_____Any other Illness_____Receive any blood by-products / Transfusions or whole blood_____

8. Is your child allergic to any food or drugs: (Penicillin, Novocain, aspirin, ect.)_____
9. Has your child ever been warned by a physician against taking any specific drug or medication?_____
   If so, please explain_____
10. Has your child ever been hospitalized for any reason?_____When?_____
    For what reason?_____

DENTAL HISTORY

1. Is this your child's first visit to a dentist?_____If not, date of last visit_____
2. Is your child having any dental problems?_____Please explain_____

_____

3. Age at which first tooth erupted_____
4. Did your child ever sleep with a bottle?_____What did the bottle contain?_____
   At what age did he or she stop?_____
5. Does you child brush his (her) own teeth?_____If not, by whom_____When?_____
6. Does your child have any speech difficulties?_____
7. What habits does your child have which might affect the teeth or mouth? Mouth breather_____Clenching or grinding or teeth_____Thumb sucking_____Sucks finger_____Other_____
8. Has your child had any dental injuries?Provide details_____
9. Has your child had fluoride supplements at home?_____Is you water fluoridated?_____
10. Dietary Summary (types and frequency of sweets)_____
11. Significant dental history in any family members (i.e. missing teeth; extra teeth; soft tissue problems; ect.)_____
12. Please add any other information or comments which you feel we should know about your child_____

RESPONSIBLE PARTY INFORMATION

Name_____
Last First Middle Marital Status

Residence_____
Street City State Zip

Home Phone_____Work Phone_____Cell Phone_____

e-mail address_____With whom does the patient live_____both____Mother____Father____Other_____

Social Security #_____Birth date_____Relationship to Patient_____

Employer_____Occupation_____

Employer Address_____
Street City State Zip

Spouse's Name_____Relationship to Patient_____
Last First Middle

Social Security #_____Birth date_____Work Phone_____

Employer_____Occupation_____

DENTAL INSURANCE INFORMATION

Insured's Name_____Social Security #_____

Insurance Company Name_____Group #_____

Insurance Company Address_____

Insurance Company Phone # _____

Insured's Employer_____

Do You Have Additional Dental Insurance Coverage? Yes No If Yes, Please Complete the Following:

Insured's Name_____Social Security #_____

Insurance Company Name_____Group #_____

Insurance Company Address_____

Insured's Employer_____

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. (If payable to the Insured, then payment is due at the time services are rendered) I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services the day they are rendered on my behalf and my dependents.

X_____**Date**_____
SIGNATURE OF PARENT OR GUARDIAN

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PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment):
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your ***Notice of Privacy Practices***, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name:_____

Relationship to Patient:_____

Signature:_____Date:_____