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_______________________Intellectual Disability_________
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:______________________