# Welcome

## Dr. Kamar Baloul

awesome kids teeth

## Health History Form

**Today's Date:** _____

**Please fill out form in Black Ink**

### 1. Tell Us About Your Child

Child's Name _____
Last First MI

Nickname: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

School_____Grade_____

Child's Home # (_____)_____

Child's Home Address:_____

_____
City State Zip

### 2. Who may we thank for referring you to our office?

_____

### 3. Parent/Legal Guardian Information

Name _____ ☐ Male ☐ Female

Email Address _____

Birthdate ____/____/____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

### 4. Parent/Legal Guardian Information

Name _____ ☐ Male ☐ Female

Email Address _____

Birthdate ____/____/____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

### 5. Who is Accompanying the Child Today?

Name _____

Relationship_____

Do you have legal custody of this child? ☐ Yes ☐ No

### 6. Person Responsible for Account

Name_____

Relationship_____

Billing Address _____

_____
City State Zip

Home # (_____)_____

Work # (_____)_____

Cellular # (_____)_____

E-mail _____

*NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service

### 7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

SS#/ Subscriber ID# _____

### 8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

## 9. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits

Y N Thumb / Finger Sucking / Pacifier

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

## 10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD

Y N Disabilities/Special Needs
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis _____
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Autism

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking_____

_____

Please list all allergies_____

_____

Child's Physician _____

Phone (_____) _____

Please describe the child's current physical health...

**Good** **Fair** **Poor**

***Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.***

## 11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

*Parent or Guardian must accompany the child.

## For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

**Awesome Kids Teeth**

**Patient Consent form for Unencrypted E-Mail Use**

Patient Name/DOB: _____

Patient/Parents/Legal Guardian address: _____

Patient/Parents/Legal Guardian e-mail address: _____

Awesome Kids Teeth offers patients the opportunity to communicate with our organization and Providers by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before giving consent. These risks include, but are not limited to:

- E-mail can be circulated, intercepted, altered, forwarded, and stored in numerous paper and electronic files.
- E-mail can be immediately broadcast worldwide and be received by both intended and unintended recipients.
- E-mail senders can misaddress e-mail.
- E-mails are archived, stored and inspected through computer system audits.
- Email can be used to introduce virus into computer systems
- Email can be used as evidence in court

**CONDITIONS FOR THE USE OF E-MAIL**

We will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, we cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by our organization. We will not use e-mail communication for matters that may be unlawful or contain PHI or sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, sexually transmitted diseases, and issues of abuse, developmental disability, or substance abuse.

**INSTRUCTIONS :** To communicate by e-mail, we will request that the patient shall:

- Limit or avoid use of his/her employer's computer.
- Keep the email concise, do not use for sensitive information information regarding STD's substance abuse, mental health or HIV/AIDS)
- Inform us of any changes in his/her e-mail address.
- Include his/her name in the body of the e-mail.
- Include specific category in the e-mail's subject line, for routing purposes (e.g., billing question).
- Review the e-mail to make sure it is clear, specific and contains relevant information before sending to our organization.
- Restricted communications from the patient must be provided if applicable.
- Withdraw e-mail consent at any time by e-mail or written communication to our organization or Provider.
- Email will not be used for urgent or emergency situations

**PATIENT ACKNOWLEDGMENT AND AGREEMENT EMAIL USE**

I acknowledge that I have read and fully understand this e-mail consent form. I understand the risks associated with the communication of e-mail between the organization and my Provider, and consent to the conditions outlined above. In addition, I agree to the instructions outlined as described, as well as any other instructions that the organization may impose to communicate with its patients by e-mail. Any questions I may have had were answered.

Patient/Parents/Legal Guardian Signature: :_____

Date

Witness Signature: _____

Date