Medical/Dental History and Consent Form

Angel Smiles Pediatric Dentistry, 23 Paoli Pike, Suite 100, Paoli, PA 19301, Tel: 610-687-4264

Child's Last Name: **First Name:** **Date of Birth:**

MEDICAL/DENTAL HISTORY

Date of last cleaning and exam_____ Reason for today's visit_____

List all the medications or drugs your child is taking:

☐ None_____

_____

_____

List medications/drugs or anything your child is allergic to:

☐ None_____

_____

_____

List any medical conditions your child may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever

☐ None_____

_____

Has your child had any of the following:	Yes	No	Comments
Has your child ever been hospitalized?	☐	☐	
Has your child ever been seriously ill?	☐	☐	
Has your child ever had surgery?	☐	☐	
Injury to the face or teeth?	☐	☐	
Pain in the teeth, or jaw pain?	☐	☐	
Swelling of the mouth and face?	☐	☐	
Does your water have fluoride?	☐	☐	
Does your child thumb suck, or have other oral habit?	☐	☐	
Had any complications following dental treatment?	☐	☐	

Name your child's Primary Physician?_____ Phone_____

Name of former dentist_____ City/State_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status

Parent/Guardian Signature_____ Date_____

CONSENT FOR SERVICES

* I request and consent to the performance of comprehensive dental treatment by Dr. Shurong Cao and her staff. I authorize any necessary radiographs (xrays) and photographs needed for the diagnosis and treatment of my child's dental condition.
* For my convenience, I hereby authorize this office to release all information necessary to my insurance company, and receive payment directly from them.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* If sent to collections, I agree to pay all related fees and court costs.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

Parent/Guardian Signature_____ Date_____

NOTICE OF PRIVACY POLICIES

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities and healthcare operations. I also understand that I have the right to revoke permission.

Parent/Guardian Signature _____ Date_____