THE CHILDREN'S DENTAL GROUP

NEW PATIENTS

Please fill out both sides of this form and make sure to sign and date each section.
Information Forms must be filled out by new patients and once each year for existing patients.

DATE ____________________

PATIENT INFORMATION

NAME ____________________ **SEX - Male** ☐ **Female** ☐

DATE OF BIRTH ____________________ **AGE** ____________

ADDRESS ____________________ **APT #** ____________

CITY ____________________ **STATE** ________ **ZIP** ____________

HOME PHONE ____________ **WORK PHONE** ____________ **CELL PHONE** ____________

EMERGENCY CONTACT (Please use a different number from those listed above.) ____________________

EMAIL ADDRESS ____________________

PARENTS' INFORMATION

MOTHER:

NAME ____________________

DATE OF BIRTH ____________________

SOC. SEC NO. ____________________

ADDRESS ____________________

(if different from patient) ____________________

EMPLOYER ____________________

FATHER:

NAME ____________________

DATE OF BIRTH ____________________

SOC. SEC NO. ____________________

ADDRESS ____________________

(if different from patient) ____________________

EMPLOYER ____________________

DENTAL INSURANCE INFORMATION

Does your child have insurance through the State Husky program? **Yes** ☐ **No** ☐

If Yes, please complete:
HUSKY ID NO. ____________________ **NAME OF PLAN** ____________________

Does your child have any other form of insurance(through a parent's employer)? **Yes** ☐ **No** ☐

If Yes, please complete:
NAME OF PLAN ____________________ **NAME OF POLICY HOLDER** ____________________

POLICY/GROUP NO. ____________________ **INSURANCE TELEPHONE NO.** ____________________

DENTAL HISTORY

How did you hear about The Children's Dental Group? ____________________

____

Is this your child's first visit to the dentist? **Yes** ☐ **No** ☐

If No, please complete:
NAME OF PREVIOUS DENTIST ____________________

DATE OF LAST EXAM OR CLEANING ____________________

PLEASE NOTE: Please call our office at (203) 787-1176 to cancel or reschedule your appointment at least 48 hours in advance.
If any patient should miss two appointments without calling in advance, that patient shall no longer be treated by this office.

825 Grand Avenue
New Haven CT 06511
(203) 787-1176
www.thechildrensdentalgroup.com

MEDICAL HISTORY

NAME OF PHYSICIAN ______________________ PHYSICIAN'S PHONE NO. ______________________

IS PATIENT TAKING ANY MEDICATION: YES ☐ NO ☐ IF YES, WHAT: ______________________

IS PATIENT ALLERGIC TO ANY OF THE FOLLOWING:

AMOXICILLIN/PENICILLIN ☐ LATEX ☐ LOCAL ANESTHETICS ☐ ASPIRIN ☐ METAL ☐

OTHER, SPECIFY: ______________________

HAS PATIENT EVER HAD A SERIOUS ILLNESS OR BEEN HOSPITALIZED: YES ☐ NO ☐

IF YES, EXPLAIN: ______________________

PLEASE CHECK ALL THE CONDITIONS THE PATIENT HAS NOW OR HAS EVER HAD:

☐ AIDS	☐ Cancer	☐ Epilepsy	☐ Leukemia	☐ Stroke
☐ Anemia	☐ Cerebral Palsy	☐ Fainting / Dizziness	☐ Liver Disease	☐ Thyroid Disease
☐ Asthma	☐ Chemotherapy	☐ Heart Murmur	☐ Lung Disease	☐ Tuberculosis
☐ Autism	☐ Cold Sores	☐ Heart Disease	☐ Psychiatric Care	☐ Tumors
☐ Blood Disease	☐ Developmental Delays	☐ Hepatitis A, B, C	☐ Seizures	☐ Ulcers
☐ Blood Disorder / Bleeding Problem	☐ Diabetes	☐ High Blood Pressure	☐ Sickle Cell Disease	☐ Wheel Chair Dependent
☐ Blood Transfusion	☐ Downs Syndrome	☐ Kidney Problems	☐ Stent	☐ Other

If other, specify: ______________________

To the best of my knowledge, I have answered every question accurately. I will inform my dentist of any changes in the patient's health.

Parent / Legal Guardian ______________________ **Date** ____________

PERMISSION FOR DENTAL TREATMENT, LOCAL ANESTHESIA (NUMBING SHOT), AND NITROUS OXIDE (LAUGHING GAS)

- I hereby authorize the dentist to treat the person under my care with the following dental procedure (if or when needed): prophylaxis (cleaning), routine x-rays, restorations (fillings), crowns, extractions, root canal, or any other treatment the dentist considers necessary.
- The dentist has or will explain to me the purpose of the procedure(s) and has also explained the benefits and risks of the treatment.
- I understand that during treatment, unforeseen conditions may arise which may necessitate procedures different from those discussed prior to treatment. I therefore consent to the performance of any additional treatment that the dentist may consider necessary.
- I consent to the use of local anesthetic, antibiotics, and analgesics and have been explained all potential risks. I understand that there is a slight risk involved with the use of local anesthesia or the use of any drug. These risks include allergic reaction, aspiration, pain, cardiac arrest, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs.
- I consent to the use of nitrous oxide analgesia (laughing gas) and have been informed of the risks and benefits of its use. I have been given no assurances or guarantees as to outcome of the treatment. I realize that in spite of the possible complication, my proposed treatment is necessary and desired by me.
- I understand that it is vital that I give as accurate and complete a medical and personal history as possible, follow any and all instructions as directed and permit prescribed diagnostic procedures. I confirm that I have fully understood all the information provided above.

Parent / Legal Guardian ______________________ **Date** ____________

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 Private 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.

Parent / Legal Guardian ______________________ **Date** ____________