Baitner
Pediatric Dentistry

Patient Information

Child #1

First Name______________ MI__________ Last Name_____________________________

Preferred Name __________________ Male / Female Birthdate________________

Child #2

First Name______________ MI__________ Last Name_____________________________

Preferred Name __________________ Male / Female Birthdate________________

Child #3

First Name______________ MI__________ Last Name_____________________________

Preferred Name _________________ Male / Female Birthdate_________________

Parent/Guardian Information

Name____ Birthdate________________

Address____

Apt / Suite ____ City ______________ State ____________ Zip___________________

Work Phone__________ Home Phone____________ Cell phone______________________

E-mail Address____

Same address/home phone number for the entire family? Y / N

If Not____

Primary Insurance

Name of Insured ________________________ DOB ___________ ID# _______________

Ins Company _______________________________ Phone ___________________________

Employer_________________ Group Name ___________ Group # ___________________

Your relationship to insured: Self / Child / Spouse

Other Questions

How did you hear about our office? ____

Preferred Contact Methods: Home Ph Work Ph Cell Ph E-mail

Time 9:30 AM | Baltner Pediatric Dentistry | Date

Baltner Pediatric Dentistry Medical History Form/Formulario de Historia Médica

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Have you ever been hospitalized or had a major operation? / Ha estado hospitalizado/a o cirugia? ◯ Yes ◯ No If yes

Are you taking any medications, pills, or drugs?/ Esta tomando alguna medicaciones o pastillas? ◯ Yes ◯ No If yes

Are you allergic to any of the following?/ Alergico/a a cualquiera de las siguentes?

- ☐ Aspirin/Aspirina
- ☐ Penicillin/Penicilina
- ☐ Codeine/Codeina
- ☐ Latex
- ☐ Sulfa Drugs/Sulfamidas
- ☐ Local Anesthetics/Anestésicos locales
- ☐ Ibuprofen/El ibuprofeno

Do you have, or have you had, any of the following?/Tiene, o ha tenido, cualquiera de los siguientes?

Condition	Answer
AIDS/HIV +/SIDA / VIH	◯ Yes ◯ No
Lung/Pulmón	◯ Yes ◯ No
Epilepsy	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No
Pneumonia/Neumonía	◯ Yes ◯ No
Rheumatic Fever/Fiebre reumática	◯ Yes ◯ No
Headaches/Dolores de Cabeza	◯ Yes ◯ No
Behavior/Comportamiento	◯ Yes ◯ No
Shunts/Las Derivaciones	◯ Yes ◯ No
Heart Disease/Enfermedad del Corazón	◯ Yes ◯ No
Brain Injury/Daño Cerebral	◯ Yes ◯ No
Cancer	◯ Yes ◯ No
Sinus Problems/Problemas del sino	◯ Yes ◯ No
Hepatitis	◯ Yes ◯ No
Congenital Birth Defect/Defecto Congénito	◯ Yes ◯ No
Speech Problems/Problemas del habla	◯ Yes ◯ No
Thyroid Issues/Problemas de Tiroides	◯ Yes ◯ No
Kidney or Bladder Problems/Problema de Riñón o Vejiga	◯ Yes ◯ No
Eyes/Ojos	◯ Yes ◯ No
Transplants/Trasplantes	◯ Yes ◯ No
Liver/Hígado	◯ Yes ◯ No
Endocrine or Hormone Disorders/Trastorno endocrino o Hormona	◯ Yes ◯ No
ADD/ADHD	◯ Yes ◯ No
Intellectual Disability/Discapacidad Intelectual	◯ Yes ◯ No
Gastrointestinal Problems/Problemas Gastrointestinales	◯ Yes ◯ No
Asthma/Airway Disease	◯ Yes ◯ No
Autism/Autismo	◯ Yes ◯ No
Seizures/Convulsiones	◯ Yes ◯ No
Heart Murmur/Sopio del Corazón	◯ Yes ◯ No
Blood or Bleeding Problems/Problemas de sangramiento	◯ Yes ◯ No
Sickle Cell Disease /Enfermedad de Célula Falciforme	◯ Yes ◯ No
Hemophilia/Hemofilia	◯ Yes ◯ No
Cerebral Palsy/Parálisis Cerebral	◯ Yes ◯ No
Skin Problems/Problemas de la piel	◯ Yes ◯ No
Infections/Infecciones	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No
Ears or Hearing/Oídos o audición	◯ Yes ◯ No
Transfusions/Transfusiones	◯ Yes ◯ No
Learning Disability/Discapacidad de Aprendizaje	◯ Yes ◯ No
Emotional Problems/Problemas Emocionales	◯ Yes ◯ No
Tuberculosis	◯ Yes ◯ No

Have you ever had any serious illness not listed above?/Alguna vez ha tenido alguna enfermedad ◯ Yes ◯ No If yes

Comments:

Dental History/Historia dental

Question	Answer	
Does an adult assist with toothbrushing?/ Ayuda un adulto con el cepillado de dientes?	◯ Yes ◯ No	
Has child received orthodontic care?/ Niño/a ha recibido tratamiento de ortodoncia	◯ Yes ◯ No	
Is this your child's first visit to the dentist?/Es la primera visita de su hijo/a al dentista?	◯ Yes ◯ No	
Any unhappy or unpleasant experiences?/ Cualquier experiencia infeliz o desagradables?	◯ Yes ◯ No	If yes
Has child complained of any dental problems?/ Se ha quejado niño/a de cualquier problema dental?	◯ Yes ◯ No	If yes
Does child have any dental/oral pain?/ El niño/a tiene cualquier dolor dental / oral?	◯ Yes ◯ No	If yes
Any history of injury to mouth, teeth, or head?/Cualquier antecedente de lesión en la boca,	◯ Yes ◯ No	If yes
Has child had dental xrays?/ Niño/a ha tenido radiografías dentales?	◯ Yes ◯ No	
Does child brush daily?/El niño/a se cepilla diariamente?	◯ Yes ◯ No	
Does child floss daily?/Esta el niño/a usando hilo dental diariamente?	◯ Yes ◯ No	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status./A lo mejor de mi conocimiento, las preguntas de este formulario han sido respondidas con precisión. Entiendo que proporcionar información incorrecta puede ser peligroso para mi salud (o del paciente). Es mi responsabilidad informar a la oficina dental de cualquier cambio en el estado médico.

Signature of Patient, Parent or Guardian/Paciente, padre o tutor:

X

Date:__________

PATIENT HIPAA CONSENT FORM

Today's Date: __________

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 a secure 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 the HIPAA. I understand that you reserve the right to change terms of this notice from time to time and that I may contact you 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 anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient 1: ______________________ Parent name: ______________________
Patient 2: ______________________ Signature: ______________________
Patient 3: ______________________

Cancellation or a No Show of an Appointment

If it is necessary to cancel or reschedule your child's appointment, we require a 24 hour notice. Please call our office during regular business hours or you may leave a detailed message with the day and time of your child's appointment.

A "no show" is someone who misses an appointment without cancelling it. If you do not show up for your appointment and you do not call to cancel, we will record this in the chart as a "no show".

Appointments are in high demand and your early cancellation will give another child the opportunity to be seen by the doctor. Failure to comply with this policy will result in a cancellation fee of $50.

Please note: Repeated "no shows" will result in discharge from the practice.

Patient 1: ______________________ Parent name: ______________________
Patient 2: ______________________ Signature: ______________________
Patient 3: ______________________