tiny teeth general dentistry llc
710 King Street
Bristol, CT 06010
860.583.8469

Patient Information and Health History Form

In order to ensure that your child receives the best care at our practice, we ask you to carefully complete this form. It is important for us to know about all parts of your child's health history. This form is completely confidential, and will be used only for dental and medical reasons.

Tell Us About Your Child

Child's Name: _____ Patient goes by: _____
FIRST MIDDLE INITIAL LAST (If applicable)

Sex: M ☐ F ☐ Birthdate: _____ Age: _____ Home Phone: _____

Address: _____
APT/UNIT # CITY/STATE/ZIP

Whom may we thank for referring you? _____

Notify in case of an emergency (other than parents): _____ Phone: _____

Relationship to patient: _____

PARENTS/GUARDIAN INFORMATION

Father/Guardian name: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Financially Responsible for patient's account? Y ☐ N ☐

Address (if diff from above): _____

Home/mobile phone: _____

Work/mobile phone: _____

Employer: _____

Occupation: _____

SSN: _____ Birthdate: _____

Email: _____

Do you have dental insurance coverage for minor/child? Y ☐ N ☐

If yes, fill out the following:

Insurance Company Name: _____

Phone Number: _____

Member ID: _____ Group ID: _____

Mother/Guardian name: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Financially Responsible for patient's account? Y ☐ N ☐

Address (if diff from above): _____

Home/mobile phone: _____

Work/mobile phone: _____

Employer: _____

Occupation: _____

SSN: _____ Birthdate: _____

Email: _____

Do you have dental insurance coverage for minor/child? Y ☐ N ☐

If yes, fill out the following:

Insurance Company Name: _____

Phone Number: _____

Member ID: _____ Group ID: _____

DENTAL HISTORY

What would you like us to do for your child today? _____

Previous Dentist: _____ Phone: _____

Date of last dental care: _____ Date of last xray: _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? Y ☐ N ☐

Has your child experienced mouth or chin injury? Y ☐ N ☐

Has your child ever experienced an adverse reaction during or in conjuction with a medical or dental procedure? Y ☐ N ☐

Does your child have speech problems? Y ☐ N ☐

Was your child bottle fed? Y ☐ N ☐

If so, how long? _____

Does your child suck his/her thumb, fingers or pacifier? Y ☐ N ☐

Is fluoride taken in any form? Y ☐ N ☐

If so, what form? _____

Other information about your child's dental health or previous treatment: _____

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MEDICAL HISTORY

Where there any difficulties during the pregnancy, delivery (e.g., prematurity) or 1st year of your child's life? ☐ Yes ☐ No
If yes, describe?_____

Medical conditions: Does your child have any history of the following? *(Check all that apply)*

General conditions
- ☐ Arthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Gastrointestinal disorders
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Kidney disease
- ☐ Rheumatic fever

Behavior/Learning ADHD
- ☐ Anxiousness/Nervousness
- ☐ Autism
- ☐ Behavior issues: Type_____
- ☐ Emotional disability:
- ☐ Type_____
- ☐ Learning disability:
- Type_____
- ☐ Psychiatric disorder:
- Type_____

Developmental
- ☐ Brain injury
- ☐ Cerebral palsy
- ☐ Cleft lip/palate
- ☐ Developmental Delay
- ☐ Feeding/Eating problems
- ☐ Growth problems
- ☐ Hearing loss: Type _____
- ☐ Neuromuscular defect
- ☐ Orthopedic problems
- ☐ Seizures: Type_____
- ☐ Speech prob: Type _____
- ☐ Spina bifida

Hematological (Blood-related)
- ☐ Anemia
- ☐ Bleeding (prolonged)
- ☐ Hemophilia
- ☐ Sickle cell trait
- ☐ Sickle cell disease
- ☐ Transfusion of blood

Infectious
- ☐ Hepatitis
- ☐ HIV infection (AIDS)
- ☐ Tuberculosis
- ☐ Venereal disease:
- Type_____

Substance use/Abuse
- ☐ Drug use
- ☐ Tobacco use
- ☐ Abuse (physical or sexual)

Other
- ☐ Cancer: Type _____
- ☐ Leukemia: Type _____
- ☐ Fainting/headaches (often)
- ☐ Sleep apnea
- ☐ Sleep problems
- ☐ Snoring
- ☐ Syndrome: Type _____
- ☐ Other: _____

If any boxes checked, please describe further: _____

_____

_____

Medications: Is your child CURRENTLY taking any medications?

Drug	How much & how often?	Reason

Steroid Use: Has your child had any steroid treatment in the past 6 months? ..... ☐ Yes ☐ No

Allergies: Has your child had any allergic reactions to:

Medications or drugs? _____

Latex?_____

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Immunizations: Are your child's immunizations current?……. ……..…… ☐ Yes ☐ No

Have you ever been told that your child needs to take antibiotics before dental treatment? ☐ Yes ☐ No

Hospitalizations: Has your child ever been hospitalized? ☐ Yes ☐ No

If yes, when, and where? _____

Reason for hospitalization? _____

Surgeries: Has your child had any surgery (operations)?…….. ☐ Yes ☐ No

Date(s) and age(s)? _____

For what reason(s)? _____

Was general anesthesia used?…….. ☐ Yes ☐ No

Were there any complications? If yes: _____ ☐ Yes ☐ No

Child's Physician/Pediatrician: _____ Phone#: _____

Mailing Address: _____ City: _____ State:_____ Zip: _____

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.

Name: _____

Signature: _____

Relationship to patient:_____**Date:**_____

***Reviewed by*: Doctor**_____**Date:**_____

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Consent For Dental Treatment

I am the parent, guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize the doctor(s) and the staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, any necessary dental treatment for my child's teeth, X-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by the doctor(s), whether or not I am present when the treatment is rendered. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. The doctor(s) will provide an environment that will help children learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. I will be responsible for any charges incurred for my child for dental treatment.

Signature:_____ **Date:**_____

_____

Please print name of Patient, Parent, Guardian, or Personal Representative

_____

Relationship to Patient

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Dr. Jamie Motyka

IMPORTANT NOTICE:

Due to Federal Mandates called Health Insurance Portability and Accountability Act, or HIPAA, healthcare providers are now required to obtain patient consent for the release of private health information.

I give Tiny Teeth General Dentistry L.L.C.; consent to release private health information for the benefit of my continued quality healthcare. Health information may be released to my primary care physician, referring dentist, insurance company or another specialist involved in my dental care. For this purpose private information is defined as personal information, examination finding and/or treatment either purpose, underway or completed. _____ Initial

I also give Tiny Teeth General Dentistry L.L.C., permission to leave appointment reminders and/or other pertinent messages in my answering machine, e-mail, or at my place of employment, per my request, and/or to contact me by post card or letter. I also understand that I may revoke this authorization, in writing, at any time. _____ Initial

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our financial coordinator. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, billing & interest charges and any other expenses incurred in collecting your account. _____Initial

As a courtesy to all our patients, we will verify your insurance coverage but it is up to the responsible party to be aware of their Plan coverage & what is covered and not covered and aware of their frequency limitations. The responsible party is responsible for any and all payments not covered by their insurance carrier. Any disputes of payment will need to be made by the covered member and the insurance company. It is not the responsibility of Tiny Teeth to resolve any disputes between the covered member & the insurance carrier. _____ Initial

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's or my medical status. I, being the parent or guardian or patient, do request and authorize the performance of dental services for this patient, and the performance of whatever procedures or techniques the Doctor may deem necessary during performance of treatment. I authorize the administration of anesthetics or analgesics which may be deemed advisable by the Doctor. _____ Initial

_____ _____

Signature Date

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Dear Parents & Patients,

In order to better serve our patients, we are now requiring the following:

- **All appointments must be confirmed within 24 hours notice of the actual appointment, if you reach our office after hours, we request that you leave a voice message on our machine.**
- **Any failed office visits, without 24 hours notice, will result in a FEE being charged to your account.**
- **If a patient fails more than 3 office visits, this may result in dismissal from our practice, not just for the specific patient who failed the visits, but for the entire family.**

Our office makes every effort to remind you of an appointment with a courtesy phone call as well as a recall postcard reminder on all hygiene visits. However, ultimately, it is your responsibility to be aware of your appointment and to be sure the appointment is kept.

Please also be aware, that since we are a children's dental office, there are times that we may run over due to the patient's behavior and/or any emergencies that may occur, and we appreciate your cooperation. The comfort and well being of your child is our number one priority and we appreciate your understanding.

_____ _____

Signature of Parent or Guardian Date

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Payment Policy

We would like to thank you for becoming a member of our dental family, and assure you of our continued commitment to excellence. In an effort to control the costs for quality dental care, we have established the following policies:

- We will need to make a copy of your driver's license and insurance card, if applicable, for our records.

- As a courtesy for our patients with dental insurance, we will file your claim if you have provided complete insurance information to us. This includes the subscriber's social security number or insurance ID number, subscriber's date of birth, subscriber's employer, insurance carrier, insurance group number and a customer service telephone number. This information is typically found on your insurance card. Although we estimate what your insurance company will pay, it is the insurance company that makes the final determination of your eligibility/coverage. **YOU ARE RESPONSIBLE FOR ANY PORTION OF THE CHARGES NOT COVERED BY INSURANCE.**

- Payment (minus any expected insurance benefit) is expected at each appointment for services rendered and can be made by cash, check, MasterCard, Visa, and DISCOVER. Our office also offers Care Credit for your convenience. This includes co-pays, non-covered expenses and deductibles.

- The parent/legal guardian who initially brings the child for examination is legally responsible for the account and payment will be expected day of service. We cannot send statements to other persons.

- There will be a $ 35.00 charge for all returned checks.

- Unfortunately there are times when a past due account is ignored. In this case, we would then need to seek payment via a third party (collection agency). If we have to pursue this in small claims court, you will be responsible for all court costs.

- Please be aware that your insurance policy is a contract between you, your employer, and the insurance company, not with Tiny Teeth.

I understand and agree to the terms stated above. _____Date _____
Responsible party/Parent