

Your child's name: _____ Nickname: _____ Birthdate: _____

Home address: _____
Street City State Zip

Father's name: _____
Employer: _____
Work phone: _____
Home or Cell phone: _____
Address, if different than child: _____

Mother's name: _____
Employer: _____
Work phone: _____
Home or Cell phone: _____
Address, if different than child: _____

Person Responsible for the account: _____

Primary insurance: _____ Insured's name: _____
Contract # or ID _____ Phone # _____
Address _____ City _____ State _____ Zip _____

Secondary Insurance: _____ Insured's name: _____
Contract # or ID _____ Phone # _____
Address _____ City _____ State _____ Zip _____

What is the reason for your visit today? (Please check all that apply. Use the space below to explain.)

- First visit to the dentist _____
- Emergency _____
- Transferring care _____
- Specific problem _____
- Pain _____

Whom may we thank for referring you to our office? _____

Getting to know your child:

Interests or hobbies? _____
Special pets or toys? _____
Siblings' names and ages? _____

Because your child is a minor, it is necessary that signed permission be obtained from the parent or guardian before any dental services can be rendered. Accordingly, please read the following statement carefully and sign below.

I understand that the information I provide on this form is essential to determine my child's dental needs and for the provision of dental treatment in a safe, effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask my respective health care provider or agency, which may release such information to you. I will notify the doctor of any change in my child's health or medication.

I authorize Dr. Chinonis and/or her staff to provide treatment for my child.

Signature of parent/guardian **Date**

Relationship if not parent

I have reviewed the above information. _____
Doctor's Signature Date

Your child's Dental History:

Your child's previous dentist: _____ Telephone: _____

Date of your child's last dental visit: _____ Were x-rays taken? _____

Please explain any "YES" answers in the blank area below:

YES NO Does your child have any dental problems now?

YES NO Do you have any concerns about your child's mouth?

YES NO Has your child had any difficulty with previous dental visits?

If so, what type of anesthesia was used?

- None
- Local anesthesia
- Nitrous oxide (gas)
- Sedation
- General anesthesia

YES NO Has your child ever worn orthodontic appliances?

YES NO Does your child snore?

YES NO Do your child's gums bleed or hurt?

YES NO Does your child experience pain from brushing or flossing?

YES NO Has your child ever had any broken teeth, injuries, or trauma to the mouth/face?

YES NO Do you assist your child with daily dental home care?

YES NO Was your child breast-fed?

If YES, for how long? _____

YES NO Was your child bottle-fed?

If YES, for how long? _____

Source of your child's drinking water? Please circle:

Bottled Purified Tap Well Other _____

YES NO Is there fluoride in your water?

YES NO Has your child been given fluoride supplements or vitamins?

Are your child's teeth sensitive to:

YES NO Hot/Cold Foods/Drinks

YES NO Biting/Chewing

YES NO Sweets

Does your child have a history of:

YES NO Sucking thumb or fingers

YES NO Biting or sucking lips/cheeks

YES NO Grinding teeth

YES NO Mouth Breathing

YES NO Chewing or biting fingernails

YES NO Chewing hard objects

YES NO Clenching jaw

YES NO Bottle or pacifier habits

Dietary Habits that may affect your child's dental health:

YES NO Likes sweets

YES NO Drinks soda

YES NO Chews gum

YES NO Eats before bed

YES NO Snacks often

YES NO Dislikes fruits/vegetables

What are your child's favorite foods? _____

How often does your child brush their teeth? _____

How often does your child floss? _____

Please use this space to explain all "YES" answers: _____

Your child's Medical History:

Please explain any "YES" answer in the blank area below.

Your child's physician: _____ Telephone: _____

Address: _____
Street City State Zip

Date of your child's last physical examination: _____

YES NO Is your child currently under the care of a physician?

YES NO Have you ever been told your child needs antibiotics or pre-medication before dental treatment?

YES NO Has your child ever had an allergic reaction to medication? If so, please check and explain below:

- o Local anesthetic _____
- o Penicillin (or other antibiotics) _____
- o Sulfa drugs _____
- o Aspirin _____
- o Barbiturates, sedatives, or sleeping pills _____

YES NO Has your child ever had an allergic or adverse reaction to any other substance, medication or food?

If YES, please describe: _____

YES NO Is your child current on their immunizations?

YES NO Does your child or anyone in your family have a history of acid reflux? If YES, whom?

YES NO Has your child ever had a blood transfusion?

YES NO Does your child have a handicap or a special need?

If YES, please describe: _____

Please check which of the following conditions your child has or ever has had:

- | | |
|--|---|
| YES NO Abnormal bleeding | YES NO Hayfever |
| YES NO Acne medications | YES NO Hearing Problems/Loss |
| YES NO ADHD (Attention Deficit Hyperactivity Disorder) | YES NO Heart Murmur |
| YES NO AIDS/HIV positive | YES NO Hemophilia |
| YES NO Allergies or Hives | YES NO Hepatitis |
| YES NO Anemia | YES NO Latex sensitivity |
| YES NO Asthma | YES NO Measles |
| YES NO Behavioral Issues | YES NO Mononucleosis |
| YES NO Cancer | YES NO Mumps |
| YES NO Chicken Pox | YES NO Neurological disorders |
| YES NO Cardiovascular Disease | YES NO Persistent Cough |
| YES NO Cerebral Palsy | YES NO Psychiatric/Psychological Issues |
| YES NO Congenital Heart Disease | YES NO Rheumatic/Scarlet Fever |
| YES NO Convulsions/Epilepsy/Seizures | YES NO Speech Impediment |
| YES NO Diabetes | YES NO Stomach Problems |
| YES NO Eating Disorders | YES NO Tuberculosis |
| YES NO Fainting Spells | |

Please use this space to explain all "YES" answers: _____

Is your child taking any of the following:

- | | |
|--|---|
| YES NO Antibiotics or Sulfa drugs | YES NO Insulin or diabetic medications |
| YES NO Anticoagulants (blood thinners) | YES NO Medicine for High Blood Pressure |
| YES NO Aspirin | YES NO Tranquilizers/sedatives |
| YES NO Cortisone or steroids | YES NO Other: _____ |
| YES NO Dilantin or other anticonvulsants | |

List any hospitalizations, surgeries, or serious illnesses and when:

_____	When? _____
_____	When? _____
_____	When? _____
_____	When? _____

Dr. Debra Chinonis, DDS
G-6111 S Saginaw St., Grand Blanc MI 48439
810-695-5226

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF
PRIVACY PRACTICES (HIPAA)**

*You May Refuse To Sign This Acknowledgement

I, _____ have received a copy of this
Office's Notice of Privacy Practices.

Print Name

Signature

Date

If this acknowledgement is signed by a personal representative on behalf of the
patient, complete the following:

Personal representative's name _____

Relationship to Patient _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of
Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (please specify)
