

# Hill Country Pediatric Dentistry

Date \_\_\_\_\_

Dr. Steve Hernandez Dr. Angie Hernandez Dr. Subash Mutyala \_\_\_\_\_

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Residence Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Residence Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ - - SS# \_\_\_\_\_ - - Driver's Lic # \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone( ) \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Phone( ) \_\_\_\_\_

Father's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ - - SS# \_\_\_\_\_ - - Driver's Lic # \_\_\_\_\_

Employer \_\_\_\_\_ Business Phone( ) \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Phone( ) \_\_\_\_\_

If we have seen any other siblings, please give their names \_\_\_\_\_

Please list any special interests, favorite toys, hobbies, etc. \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Relative or Friend's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

## MEDICAL HISTORY

Child's Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone( ) \_\_\_\_\_

Date of last Physical Exam \_\_\_\_\_ Results \_\_\_\_\_

	YES	NO
Does your child have regular medical exams? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is child receiving any medication or drugs? If yes, what? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever had a blood transfusion? If yes, when? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has your child ever been hospitalized? If yes, reason? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has child ever had surgery? If yes, reason? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is there any allergy to penicillin or other drugs? If yes, what? _____	<input type="checkbox"/>	<input type="checkbox"/>
Summary (for doctor's use) _____		

## Has this child ever been diagnosed with any of the following? Please check yes or no.

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Otitis (Ear Infection)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV (Aids)	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifada
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Syndrome _____
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions / Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	<input type="checkbox"/>	Dev. Delayed	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems			

## DENTAL HISTORY

	YES	NO
Date of last dental visit? _____	<input type="checkbox"/>	<input type="checkbox"/>
Has your child complained about dental problems? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have there been any unhappy dental experiences? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth, head or teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Any history of thumb sucking, finger sucking, lip biting or tongue thrusting? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your child brush and floss teeth daily? _____	<input type="checkbox"/>	<input type="checkbox"/>
Is fluoride taken in any other form than in toothpaste? _____	<input type="checkbox"/>	<input type="checkbox"/>

(over)

**FINANCIAL ARRANGEMENTS**

**Payment for Dental Treatment is Expected When Services Are Performed.**

We accept check, cash, VISA, MasterCard and Discover Card. If you have dental insurance, we will be happy to file any claims, however, you are still responsible for your account. Dental insurance coverage on your child rarely covers all expenses. Obligation for payment still belongs to you. You will receive a monthly statement each month—accounts are due and payable monthly as work progresses, regardless of insurance coverage. Any overpayment to your account will be refunded to you when your child’s dental work is completed. **There will be a \$25 dollar charge for missed appointments in which 24-hour notice is not given.** After two missed appointments without notifying our office 24 hours before the missed appointment, patient will be dismissed from our practice. In addition, should your account become delinquent, you will be responsible for any and all legal fees, court costs, and collection charges.

Signature: \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR SPECIAL TREATMENT**

**State Law requires us to obtain your consent for contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be glad to explain it.**

1. I hereby authorized and direct Dr. Hernandez assisted by other dentists and / or dental auxiliaries of his or her choice to perform upon my child (or legal ward) dental treatment or oral surgery procedure(s), including the use of necessary or advisable local anesthesia, radiographs (X-Rays), or diagnostic aids.
2. In general terms the dental procedure(s) or operation may include:
  - A. Cleaning of the teeth and application of topical fluoride
  - B. Application of plastic “sealants” to the grooves of teeth
  - C. Treatment of diseased or injured teeth with dental restorations (fillings or crowns)
  - D. Replacement of missing teeth with dental prosthesis
  - E. Removal (extraction) of one or more teeth
  - F. Treatment of diseased or injured oral tissues (hard and/or soft)
  - G. Treatment of malposed (crooked) teeth and /or oral development or growth abnormalities
  - H. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures
  - I. Use of sedative drugs to control apprehension and/or disruptive behavior (including Demerol, Phenergan, and Nitrous Oxide/Oxygen)

Exam: A routine dental exam may include: Oral examination, dental x-rays, a dental cleaning with fluoride application, a consultation with Dr. Hernandez. All x-rays are the property of this office.

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied as to the result of the treatment or as to cure. I further authorize the doctor to perform other dental services that in his/her judgement are advisable for my child or legal ward, with the exception of (if non, so state)

3. Although their occurrence is extremely rare, some risks have been reported to be associated with dental or oral surgery procedures. State Law requires us to mention the possible risk of numbness, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, quadriplegia, paraplegia, the loss of function of any organs or limb, or disfiguring scars associated with such procedure(s). I further understand and accept that complications may require hospitalization and may even result in death.

It is our office policy that parents do not accompany patients during dental restorations and/or sedation procedures. This is so that we can develop a better rapport with your child (by one-on-one interactions) and so that your child has our undivided attention.

I hereby state that I have read and understand this consent, and that all questions have been answered in a satisfactory manner and I understand that I have the right to be provided with answers to questions which arise during the course of my child’s treatment. I further understand that this consent will remain in effect until such time as I choose to terminate it.

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_