Your child's overall health as well as any medications that your child takes could have an important relationship with the dental care your child needs and is able to receive safely. Please answer each of the following questions completely.

PATIENT NAME_____ **DATE OF BIRTH**_____

HEALTH HISTORY:

Asthma	yes or no	Rheumatic Fever	yes or no
Allergies	yes or no	Congenital Heart Defect	yes or no
Cancer	yes or no	Handicaps/Disabilities	yes or no
Hepatitis	yes or no	Seizures/Epilepsy	yes or no
HIV/AIDS	yes or no	Tuberculosis	yes or no
Hemophilia	yes or no	Abnormal Bleeding	yes or no
Diabetes	yes or no	Heart Murmur	yes or no
COVID-19	yes or no		

Please explain **any medical problems** that your child has and **list any medications** they are taking: _____

_____

_____

DENTAL HISTORY:

Has your child had difficulty with previous dental visits?_____

How often does your child brush?_____ floss?_____

Previous Dentist and last appointment date_____

Child's Physician_____ Physician's Phone # _____

Is your water fluoridated____ Does or has your child taken fluoride supplements_____

Circle all the apply to your child: suck thumb/finger suck/bite lips bite/chew hard objects

grind teeth clench jaws other Please explain other_____

AUTHORIZATION AND RELEASE 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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third part payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian if minor_____ **Date** _____

DENTIST REVIEW

Notes_____ Dr. Signature _____Date_____

Notes_____ Dr. Signature _____Date_____

Notes_____ Dr. Signature _____Date_____

Notes_____ Dr. Signature _____Date_____

I, (printed name of parent/legal guardian)_____ give permission for the following person/people to bring my child/children to the dental office to be treated by Dr. Severson. Until further notice, the following people are able to make decisions regarding any dental and/or medical treatment necessary while under the care of Dr. Severson. This permission includes, but is NOT limited to cleanings, fluoride, x-rays, fillings, crowns, extractions, laughing gas (nitrous oxide), conscious sedations, space maintainers, sealants, emergency treatment, impressions, local anesthesia (Novocain), nerve treatment for a tooth, and referrals to another dentist or doctor.

People who can make decisions:

Parents:_____

Grandparents:_____

Nanny:_____

Other:_____

Child this consent applies to:

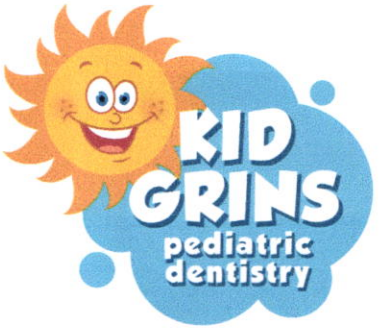
Child's Name:_____

Signature of parent/legal guardian_____

Date:_____

Relationship to patient/patients:_____

*** PLEASE NOTE: AN ADULT MUST BE PRESENT FOR THE ENTIRE APPOINTMENT. THIS ADULT MUST BE AN ADULT THAT IS ABLE TO CONSENT TO TREATMENT FOR THE CHILD/PATIENT. ***



Please sign only one of the sections below. It should be the section that you agree with.

KID GRINS PEDIATRIC DENTISTRY PRIVACY AND CONSENT FORM:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health/dental information to carry out treatment, payment activities, and healthcare operations.

I, _____ have received a copy of
(Parent/Legal Guardian Name)

Kid Grins Pediatric Dentistry Notice of Privacy Practices.

_____

Name of Patient

_____

Signature of Parent/Legal Guardian

Date_____

OR

REVOCATION OF CONSENT:

I revoke my consent for your use and disclosure of my protected Health/Dental information for treatment, payment activities, and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat my child/children after I have revoked my consent.

I also understand that if I do not include my social security number, the office will not be able to submit insurance claims for your children. This means that you are responsible to pay, in full, for treatment on the day of service.

_____

Name of Patient

_____

Signature of Parent/Legal Guardian

Date_____