Patient Health Information

Patient's Last Name: ___________________Middle Initial: _____ Patient First Name: ________________________

1. Does patient have any health problems? [ ] YES [ ] NO Explain:_______________________
2. Has patient ever been hospitalized? [ ] YES [ ] NO Explain:_______________________
3. Does patient see a physician for his/her general health? [ ] YES [ ] NO Explain:_______________________
4. Does patient bleed excessively when cut or bruise easily? [ ] YES [ ] NO Explain:_______________________
5. Has patient had emotional or mental problems? [ ] YES [ ] NO Explain:_______________________
6. Has patient ever had a local anesthetic? [ ] YES [ ] NO Explain:_______________________
7. Has patient had any injuries to the mouth or teeth? [ ] YES [ ] NO Explain:_______________________
8. Does patient have a toothache today or in the past month? [ ] YES [ ] NO Explain:_______________________
9. Is patient currently pregnant? [ ] YES [ ] NO If "Yes" How many weeks?_____________
10. Does patient have history of any joint replacements? [ ] YES [ ] NO Explain:_______________________
11. Has patient ever had any drug reactions, is allergic to any medications, foods or drink, environmental allergies or/and is allergic to any materials commonly used in a dental office (i.e. latex gloves, anesthetic, etc.)? [ ] YES [ ] NO Explain: _______________________

Smoking status for teens: [ ] Currently Smoker [ ] Never smoked before.

Current Smoker: How frequently do you smoke? ____

Other forms of tobacco: [ ] Yes [ ] No. If yes, please explains: ______________________________________

Please list prescription/non-prescription medication(s) being taken by the patient: ____________________________

Has patient ever had any history or difficulty with the following? Circle any that apply.

Asthma	Hearing	Thumb/finger sucking	Cancer	Cerebral Palsy
Autism	Pinworms	High Blood Pressure	HIV	Sickle Cell Anemia
ADHD	Skin Condition	Thyroid	Anemia	Kidney problems
Heart problems	Rheumatic Fever	Snoring	Mononucleosis	Lung problems
Speech Problems	Hepatitis	Tongue Thrust	Cystic Fibrosis	Fainting
Developmental Delay	Hydrocephaly/Shunts	Mouth Breathing	Nervous Disorder	Seizures
Tuberculosis	Convulsions	Belching/Burping	Liver	Spina Bifida
ADD	Measles	TMJ	Cleft Lip or Palate	Bladder
Diabetes	Hemophilia	Mumps	Heart Surgery	Congenital Defect

Please explain: ____

CONSENT FOR TREATMENT: I certify that I am the patient or parent/legal guardian of the patient listed above and the information provided in this form is true and correct to the best of my knowledge. By signing the form below, I give consent to LPPD to perform diagnostic/preventive procedures (X-rays and cleaning). After consultation regarding the treatment plan, I give consent to all required treatment and understand that I am responsible for any portion of the payment that is patient's responsibility.

Signature: ____

Relationship to Patient (if patient is minor) _______________________________ Date: ____________

Dentist Signature: ____ Date: ______________

Patient Information

Patient's Last Name: _______________________ Middle Initial: ____ Patient First Name:__________________

Date of Birth: ____ Age: ______________ Sex:___________

Parent/Guardian's name: _____________________________________ Date of birth: _____________________

Phone Number: (Home) __________________________________ (Mobile) _______________________________

Home Address: __________________________City_________________________ State____ Zip____________

Email: ____

Primary language spoken by Patient: [ ] English [ ] Spanish [ ] Other_____________________________

Race:

[ ] American Indian or Alaska Native [ ] Black or African American [ ] White [ ] Other Race

[ ] Native Hawaiian or Other Pacific Islander [ ] Hispanic or Latino [ ] Asian [ ] Declined to Specify

Diet: [ ] Vegetarian [ ] Mixed [ ] Special diet

Juice: [ ] More than 3 cups per day [ ] 2 cups per day [ ] Less than 1 cup per day

Snacking: [ ] More than 3 per day [ ] 2 times per day [ ] 1 time per day [ ] No Snacks

Brushing: [ ] 2 times per day [ ] 1 time per day [ ] Few times per week

Flossing: [ ] Everyday [ ] Few days per week [ ] Rarely [ ] Never

How did you hear about us? [ ] Referred by _____- [ ] Internet [ ] Flyer [ ] Drive by [ ]

Previous dentist(Name):____

Reason for finding a new dental office: ____

Has patient had any unfavorable dental experiences? [ ] **YES** [ ] **NO** Explain: ____________________________

When was the last dental visit and frequency of visits? _______________________________________

Reason for today's visit: ____

Name and phone # of patient's pediatrician or physician: ______________________________________

Name and phone # of any specialty medical care providers: ____________________________________

Please list your preferred pharmacy name, location, and phone number: __________________________

Little Pearls Phone/ Electronic Device Policy

You are free to quietly use your phone and other electronic devices in our lobby:

- You may take pictures of your children in our lobby. Please refrain from taking pictures of the staff and/or of our other patients being treated.
- No use of electronic devices will be allowed in the operatory by the parent.
- When in the operatory ABSOLUTELY no forms of video/audio recordings or photography will be allowed. If we see you doing so, your child's procedure will be aborted and you will be asked to leave the room immediately.
- We want to have your child's undivided attention and in turn we want to provide the best care possible without any distractions. So, if you need to make or receive a phone call, please excuse yourself to the waiting area.

I have read, understand and agree to this policy. I understand that any pictures, audio or video recording outside of those authorized above, created in the dental office, will be the exclusive property of the dental office, and I may not use, display or distribute those files in any way.

____

Patient Name

____________________________________ ________________

Patient/Parent/Guardian Signature Date

Consent for Behavior Guidance

Patient Name___________________________________

Behavior guidance is the process by which doctor and staff helps patients identify appropriate and inappropriate behavior. Our goals are to establish communication, alleviate fear and anxiety, deliver quality dental care, build a trusting relationship between dentist/staff and child/parent, and promote the child's positive attitude toward oral health care. All efforts will be made to obtain the cooperation and trust of the child through the use of friendly persuasive techniques such as Tell/Show/Do, positive reinforcement, and voice control. In certain circumstances we may need to use additional methods to encourage your child to participate such as:

- **Patient Immobilization by the Dental staff or parent:** The Dental staff or parent will gently hold the child's hand or upper body, stabilizing the child's head, or positioning the child on the dental chair to limit the child movement.

- **Medical Immobilization/Papoose Board:** We utilize approved immobilization aids for limiting the child's unanticipated movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is comfortably placed in the pediatric immobilization aid and placed in a reclined dental chair.

- **Nitrous Oxide**: Nitrous Oxide/Oxygen inhalation also known as laughing gas may be used to reduce anxiety, produce analgesia, and enhance communication between the dentist and the patient. Using this procedure will keep the patient relaxed and conscious during the treatment. The child will not become unconscious. This is used as an adjunct to the local anesthetic administered.

All these methods are approved by AAPD (American Academy of Pediatric Dentistry

I ______________________, (parent/guardian) of __________________ acknowledge that I have read and understand the "Pediatric Behavior Guidance Techniques" above and give consent for their use. All of my questions have been answered to my satisfaction.

________________________________	________________________________	________________
Patient/Parent/Guardian Signature	Relationship to Patient	Date

HIPAA Compliance

I, ______________________, the parent/ legal guardian of _______________________ understand that by signing this Consent form, I am giving my consent to Little Pearls Pediatric Dentistry to disclose and discuss my protected health information to carry out treatment, payment activities, and health care operations with the following family member/s:

Name: ____

Relationship: ___________________________________

Date: ____

In addition I also give consent to share the health information when requested with other health care providers who provide care to my child outside of LPPD.

Right to revoke: You will have the right to revoke this consent at anytime by giving us a written notice of your revocation submitted to the LPPD compliance Officer Dr. Afshan Bintory.

I request LPPD restrict the disclosure of my PHI to those specified below:

Name: ____

****

Parent/ Legal guardian (Name): ________________________________

Signature of parent/LG ____

Relationship to the patient: ______________________________

Today's date: ____