232 W. 61st Street
New York, NY 10023
toothworksnyc.com

Office: 646-558-6058
Fax: 646-558-6059
info@toothworksnyc.com

Child Health/Dental History Form

Child's Name: LAST FIRST	Nickname:	Date of Birth: / /
Address: STREET ADDRESS AND APT # CITY STATE ZIP		Gender: Male Female
Parent 1 info: mother father legal guardian NAME PHONE	Parent 2 info: mother father legal guardian NAME PHONE	
Email address (for appointment reminders):	How did you hear about our office?	

Dental Insurance Co. Name: ID #: Group #:

Primary insured (from above): Parent 1 Parent 2 Date of Birth: SSN:

Please list the name and number of your child's pediatrician as well as any frequently seen specialists, if applicable:

Name of pediatrician: ______________________________ Number: ____________________

Name of alternate physician/specialist: ______________________________ Number: ____________________

Please review **carefully** and check (☑) if your child has any history of, or condition related to, any of the following:

Anemia	Cancer	Epilepsy/Seizures	Latex Allergy	Sickle Cell Anemia	STD
Arthritis	Cerebral Palsy	Fainting	Liver/Hepatitis	Snoring	Vision disorders
Asthma	Chicken Pox	Growth Problems	Measles	Speech/Hearing	Other (write below):
Autism	Chronic Sinusitis	Headaches	Mononucleosis	Skin	
Bladder/Kidney	Diabetes	HIV+/AIDS	Mumps	Thyroid	
Bleeding disorders	Ear Aches/Infection	Hyperactivity	Pregnancy (teens)	Tobacco/Drug Use	
Bone disorders	Enlarged tonsils	ADHD/ADD	Rheumatic Fever	Tuberculosis	NONE

YES NO

Please complete the following health/dental questionnaire:

1. Is your child taking any medications (prescription, over-the-counter, vitamin supplements)?
   Please list all: ______________________________
2. Is your child allergic to any of the following? Please explain details if YES:
   Medication allergies? ______________________________
   Food allergies? ______________________________
   Metal allergies? ______________________________
   Seasonal or other? ______________________________
3. Has your child been hospitalized or had any surgery? Please explain: ____________________
4. Has your child ever received sedation or general anesthesia? ____________________
5. If YES to #4, were there any complications? Please explain: ____________________
6. Does your child have any mental, developmental, or physical impairments?
   Please explain: ______________________________
7. Has your child ever experienced excessive bleeding when cut or injured?
8. Does your child have any genetic or inherited disorders?
   Please explain: ______________________________
9. Is your child being treated for any other illnesses not yet discussed on this form?
   Please explain: ______________________________
10. Are your child's immunizations up to date? If NO, please explain:____________________

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YES NO

11. Is this your child's first dental visit? If not, date of last visit? ____________________
12. Have there been any injuries to your child's mouth, teeth, or head?
    Please explain when/how: ____________________
13. How often are your child's teeth brushed per day? _________ Time(s) of day? AM PM Mid-day
14. Brushing is: done by an adult supervised none of the above (child brushes alone)
15. Is fluoride toothpaste used?
16. Does your child participate in any sports or other recreational activities? ____________________
17. Has your child complained of any recent dental pain? Please explain: ____________________
18. Are there any other concerns not yet discussed on this form?
    ____

Habit and Dietary Questionnaire:

- **Breast-feeding:** past; age when stopped: current; times per day? never
- **Bottle use:** past; age when stopped: current; contents: never
- **Sippy cup use:** straw spout not used
- **Pacifier use:** past; age when stopped: current never
- **Thumb/finger sucking:** past, age when stopped: current never

Please indicate the level of consumption for each of the items below:

- **Juice intake:** daily 1-2 times per week rarely/never
- **Flavors in milk (i.e. - chocolate, vanilla, strawberry, etc.):** daily 1-2 times per week rarely/never
- **Sticky foods (i.e. - dried fruits, fruit snacks, etc.):** daily 1-2 times per week rarely/never
- **Carb-rich snacks (i.e. - chips, cookies, crackers, etc.):** daily 1-2 times per week rarely/never
- **Does your child have any food/milk after brushing at night?** regularly 1-2 times per week rarely/never

As this child's parent or legal guardian, I acknowledge that the completed information in this form is correct to the best of my knowledge. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during treatment. Additionally, I have read the office policies and agree to abide by them.

____________________ Parent/Legal Guardian Signature
____________________ Print Name
____________________ Today's Date

Office Use Only

____________________ Dentist Signature
____________________ Name

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Office Policies

To create an efficient environment, we have established some office policies. By making an appointment at Tooth Works, you agree to abide by these policies or be subject to dismissal from the practice. Please read them carefully.

LATENESS: Please arrive 15 min before your appointment to address any insurance or payment issues beforehand. To avoid compromising care, and in fairness to other patients, late patients will be rescheduled if there is insufficient time for your child. We strive to minimize wait times for all patients

MISSED APPOINTMENTS: The parent/legal guardian is subject to a charge of $25-75 for a missed appointment or late cancellation of less than 48-hour notice via phone/email. Although we understand last minute issues arise, and offer limited leniency in these cases, this policy is in place to discourage from repeatedly missing/canceling appointments, which affects other patients. Those with repeated issues will also not be allowed to schedule appointments during peak hours or may be subject to dismissal from the practice

PHOTOS: We understand the desire to take pictures of your child for memories and are happy to comply provided that you inform us first so that staff does not appear in pictures without their consent. However, there is absolutely **no** recording of any kind.

X-RAYS: your dentist may recommend x-rays for your child for comprehensive diagnosis of cavities or other oral issues. The type and number of x-rays will be customized for your child's needs and can be further discussed with your dentist. If you wish, despite this recommendation, to decline x-rays for your child, you will be asked to sign a form expressing that decision. Refusal to complete said form will result in dismissal from the practice.

FINANCIAL: Payment is due for services rendered at time of treatment. The adult accompanying your child to the visit is responsible for payment the day of the visit. We accept cash and major credit cards; unfortunately, we do not accept personal checks.

- Payment plans: in very limited cases, a payment plan may be offered. A credit card authorization form will be completed with the scheduled payments as determined by the billing manager with an added service fee. This must be discussed **prior** to starting any treatment.
- Late charges, $25 per incident, may be applied in the event of outstanding balances after 2 weeks of notice. Tooth Works may contact you via phone, email, or invoice sent to your home regarding a balance. Failure to pay may result in delinquency on your account, subject to dismissal from the practice, and may be turned over to our outside financial agency.

INSURANCE: At Tooth Works, we offer the best care for each individual regardless of insurance status. Insurance information must be provided **72 hours before** the visit to allow sufficient time to confirm benefits; those without information beforehand will have to pay for the visit. We will check benefits beforehand and inform you of any co-pays. However, this is not a guarantee of payment and you may be subject to a higher co-pay if the insurance does not pay the claim as expected. You are ultimately responsible for the balance on your account. Your insurance is a contract between you and the company, not our office, and companies can at times provide incorrect information. If you wish to have an exact guarantee of payment, a pre-determination can be sent prior to treatment.

In-network: We are in-network with a few select insurances (subject to change). This means that we have agreed to accept a 'reduced fee for services'. However, you may still have out-of-pocket expenses based on your level of coverage.

Out-of-network: If your insurance falls into this category, we will still accept your insurance, inquire regarding your specific out-of-network benefits (if any), and submit the necessary claims. Keep in mind that your out-of-pocket expense will depend on your individual plan and may be subject to change once the claim has been received.

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PATIENT HIPAA AWARENESS

With my permission, Tooth Works may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Tooth Works Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Tooth Works reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

With my permission, the office of Tooth Works may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of Tooth Works may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and or Confidential.

With my permission, the office of Tooth Works may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Tooth Works restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this, I am allowing Tooth Works to use and disclosure my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

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Signature of Patient or Legal Guardian

____________________________________ ____________________
Print Name of Parent/Legal Guardian Date