DINO DENTAL
Breastfeeding.Orthodontics.Pediatrics

CHILD'S FULL NAME: _____

BIRTHDAY:_____**AGE**_____**MALE / FEMALE**

MEDICAL HISTORY

Who is your child's current pediatrician? Name/Clinic _____

1. Is your child taking any medication (prescription or over the counter), vitamins or supplements? **YES NO**
   - List name, dose and frequency: _____
2. Is your child under the care of a physician for any medical condition at this time? **YES NO**
   - If yes, please explain: _____
3. Has your child ever been hospitalized, had surgery or been treated in an emergency room? **YES NO**
   - If yes, date and please explain: _____

DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS?

Anemia / Blood Disorder	**Y**	**N**	Bladder / Kidney Problems	**Y**	**N**
Asthma / Difficulty Breathing	**Y**	**N**	Liver Disorder	**Y**	**N**
Allergies to Food / Latex / Seasonal / Other	**Y**	**N**	Allergic Reaction to Anesthetic / Antibiotics / Other	**Y**	**N**
Cancer / Tumors / Chemo or Radiation Therapy	**Y**	**N**	Thyroid Disorder	**Y**	**N**
Diabetes / Hyperglycemia / Hypoglycemia	**Y**	**N**	Birth Defects / Syndromes	**Y**	**N**
Cerebral Palsy / Epilepsy / Seizures	**Y**	**N**	Vision / Hearing / Speech Problems	**Y**	**N**
Heart Defects / Heart Disease / Murmur	**Y**	**N**	Behavioral / Emotional Issues / ADD / ADHD	**Y**	**N**
HIV / AIDS	**Y**	**N**	Developmental Disorders / Learning Problems / Delays	**Y**	**N**
Hepatitis	**Y**	**N**	Autism / Autism Spectrum Disorder	**Y**	**N**

For each **YES** provide details here: _____

_____

DENTAL HISTORY

Has your child ever been treated by a general or pediatric dentist? **YES NO**

- If so, who?_____Date of last visit: _____

1. How do you expect your child to respond to dental treatment? **WELL FAIR POOR**
2. Is there a family history of cavities? **YES NO** If yes, who? **FATHER MOTHER SIBLING(S)**

DO ANY OF THESE **CURRENTLY** APPLY TO YOUR CHILD?

Cavities / Pain from Teeth	**Y**	**N**	Sucking Habits (finger, thumb, pacifier, other)	**Y**	**N**
Injury to Teeth / Mouth / Head / Lips	**Y**	**N**	Non-Spill Training Cup (sippy cup)	**Y**	**N**
Breast or Bottle Feeding	**Y**	**N**	Stained or Discolored Teeth	**Y**	**N**

I am the parent or legal guardian for the above referenced child and am authorized to consent to dental treatment for such child. I have complete knowledge of this child's medical/dental history to accurately and fully complete this form for the child.

Parent / Legal Guardian Signature Date

Please email form to info@briargatepediatricdentistry.com or fax to 719-260-1640

AUTHORIZATION STATEMENTS

_____ (initial)

I do hereby authorize Dr. James Busch, Dr. Lauren Busch and their staff of Briargate Pediatric Dentistry to provide my child with diagnostic and therapeutic procedures, including dental x-rays and photographs, as may be necessary for proper dental care.

_____ (initial)

I do hereby understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment by using praise, explanation, and demonstration of procedures and instruments using variable voice tones. I authorize this Dental Office to administer such medication, including the use of nitrous oxide ("laughing gas"), which is a mild sedative that is inhaled to reduce anxiety and/or the use of a mouth prop.

_____ (initial)

I do hereby authorize payment directly to this Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and that any estimate given to me is not guaranteed. I authorize the release of any information relative to all claims. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Colorado or any other state.

_____ (initial)

I acknowledge that I have read your Notice of Privacy Practices in accordance with The Health Insurance Portability & Accountability act of 1996 (HIPAA), and have been offered a copy of it.

☐ **I AGREE**

OR

and grant full permission for Briargate Pediatric Dentistry to use either myself or my child's name & photograph in any publication or advertising materials (printed or electronic). This consent always waives the rights of privacy or compensation for the use of photo or name.

☐ **I AGREE**

OR

grant full permission for Briargate Pediatric Dentistry to use either myself or my child's photograph only, in any publication or advertising materials (printed or electronic). This consent always waives the rights of privacy or compensation for the use of photo.

☐ **I DO NOT AGREE**

to have mine or my child's information or photograph used.
Whom may we release information to?

Whom may we release information to?

_____

The information on this page, including the medical history, is correct to the best of my knowledge. I understand that if any of the above information changes, including medical history, that it is my responsibility to inform this Dental Office.

_____ _____

Signature of (circle one): Mother Father Grandparent Guardian *Date*