CHILD MEDICAL HISTORY FORM

Our doctors and team would like to welcome you and your child to our office! Our goal here at Jacaranda is to make every child's visit pleasant and educational. We strive to teach good care that will enable your child to have a beautiful smile that lasts a lifetime.

Today's date: ___/___/____ Language Spoken: _____

Translation Needed? Y / N

Braille, TTY or Sign Language Services needed? Y / N

Whom may we thank for referring you to our office?

_____

Child's Name:

_____

First Last Middle

Date of Birth: ___/ ___/ ____ Male: ___ Female: ___

***Child's* Address:** _____

City: _____Apt #: _____State: _____ Zip: _____

How long have you been at this address? _____

Nickname: _____

Instagram Name: _____

Facebook Name: _____

School: _____

Grade: ___ Hobbies: _____

List brothers/sisters: _____

_____

Any family members/friends treated in our office? Y / N

Who is responsible for making appointments?

Name: _____

Best contact number for appointments:

1. _____-_____-_____
2. _____-_____-_____

Who is accompanying your child today?

Name: _____

Relation: _____

Do you have custody? _____

Parental marital status: (Continues in next column)

Single____ Married____ Separated____ Widowed____

Mother's Name: _____

D.O.B.: _____ / ____ / _____ SS: _____-_____-_____

Driver's License #: _____

Address: _____

Cell: (_____) - _____- _____ Home: (_____) - _____-_____

Email: _____

Employer: _____

Job Title: _____

Father's Name: _____

D.O.B.: _____ / ____ / _____ SS: _____-_____-_____

Driver's License #: _____

Address: _____

Cell: (_____) - _____- _____ Home: (_____) - _____-_____

Email: _____

Employer: _____

Job Title: _____

Person Responsible for Account: _____

Dental Insurance Information:

Carrier: (i.e. Aetna, Metlife, etc.) _____

Phone: (_____) - _____-_____ Group #: _____

Policy Holder Name: _____

Employer: _____

D.O.B.: _____/ _____/ _____ S.S. #: _____-_____-_____

I.D. #: _____

Physician Information:

Y / N…..Is your child under the care of a physician?

Name: _____

Address: _____

Phone: (_____) - _____-_____

Y / N…..Is your child allergic to any foods? Please list:

_____

Y / N….. Allergy to any drugs

Please list ***all*** allergies to any medications:

_____

_____

Please list ***all*** medications that your child is currently taking: (including Tylenol, Multi-Vitamins, or Birth Control)

_____

_____

Please describe your child's physical health:

Good _____ Fair _____ Poor _____

Y / N…..Has puberty begun?

Y / N…..Has menstruation begun?

Y / N…..Has your child had their adenoids or tonsils removed?

Y / N…..Have you ever been told that your child needs to be pre-medicated prior to any dental appointment?

Has your child ever had any of the following medical problems?

Y / N….. Abnormal Bleeding

Y / N….. Hemophilia

Y / N….. Heart Murmur/Seizures (Circle one)

Y / N….. Operations: _____

Y / N….. Allergy to latex/metals

Y / N….. Convulsions

Y / N….. Diabetes

Y / N….. Handicap/Disabilities: _____

Y / N….. HIV+ / AIDS

Y / N….. Hospital stays: _____

Y / N….. Kidney/ Liver problems

Y / N….. Rheumatic/ Scarlet Fever

Y / N….. Hepatitis

Y / N….. Cancer

Y / N….. Asthma

Y / N….. Tuberculosis

Y / N….. Heart defects

Please discuss any medical problems that your child has:

_____

_____

General Dentist: (if recommended to our office or have had a previous general dentist)

Name: _____

Phone: (_____) - _____ - _____

Date of last visit: _____

Y / N…..Have there been any injuries to the face, mouth, teeth or chin?

Y / N…..Has your child ever had any pain/tenderness in his/her jaw joint (TMJ)?

Does your child have any of the following habits?

Y / N….. Clenching Teeth

Y / N….. Speech Problems

Y / N….. Tongue Thrusting

Y / N…..Nursing/ Bottle Habits

Y / N…..Thumb/ Finger Sucking

Y / N….. Lip Biting/ Sucking

Y / N….. Nail Biting

If you are here to see the *Orthodontist*:

What are the main concerns you would like the orthodontist to address/accomplish?

_____

Y / N….. Has your child ever been evaluated by or treated by an orthodontist before?

List any musical instruments played:

_____

If you are here to see the *Pediatric Dentist*:

Y / N….. Is this your child's first visit to the dentist?

If no, when was the first visit? _____

Y / N….. Has your child ever had an unfavorable dental experience?

How long since x-rays have been taken? (If at all) _____

Y / N….. Has your child ever had local anesthetic? Y / N….. Any unfavorable reaction to it?

Y / N….. Do you live in an area with fluoridated water?

Y / N….. Do you drink/cook with well water?

Y / N….. Does your child use a fluoride rinse?

Y / N….. Does your child floss?

Y / N….. Does your child brush his / her teeth daily?

How would you describe your child's temperament?

_____

I understand the information I have given is true and correct to the best of my knowledge, it will be held at the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. I understand credit bureau information may be obtained for office payment plans.

X _____ Date: _____/_____/_____

Signature of parent/guardian

If 18 years and over, do you have an advanced directive (living will or power of attorney)?..... Y / N

OFFICIAL USE ONLY: I verbally reviewed the medical and dental information with the parent/guardian and patient named herein _____

Notes:

_____

_____

Initials: _____ Date: _____/_____/_____

Agreement to Receive Electronic Communication

Patient Name: _____Date of Birth: _____

I agree that the dental practice may communicate with me electronically at the email address below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails.

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling: 954-452-9988 OR INFO@PLANTATIONBRACES.COM

Patient/ Legal Guardian Signature: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Name: _____
Signature: _____
Date: _____

FOR OFFICIAL USE ONLY

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify): _____

Welcome to Our Office

We thank you for bringing your child to our office and we will do our best to ensure a great experience for your child. We invite you to stay with your child during the initial examination as this will give you an opportunity to see the staff in action and allow the doctor to discuss dental findings and treatment directly with you. During future appointments, we suggest you allow your child to accompany our staff through the dental experience. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome apprehension, and we are all highly experienced in helping children overcome anxiety. Separation anxiety is not uncommon in children, so please try not to be concerned if your child exhibits some negative behavior. This is normal and will soon diminish. Studies and experience have shown that most children over the age of 3 react more positively when permitted to experience the dental visit on their own and in an environment designed for children.

- ***We strive to make each and every visit to our office a fun one!***

- Our office believes in utilizing an open friendly environment to make your child feel welcome. In doing so, we may display your child's first name in our office. Examples of this include our Welcome board, No Cavity Club board and our daily schedules. Every effort is made to keep information to a minimum.

- If your child is under the age of 6 Dr .Rene (our pediatric dentist) will see your child in the morning. In our experience, we have found that younger children tend to do better when they are well rested.

- **If you cannot keep an appointment, please give 48 hours of notice so that we may cancel or reschedule an appointment**. Rescheduling may result in a less desirable appointment time and may result in extending your treatment time. Please remember that we schedule time with Dr Rene and Dr. Khakhria for your child, therefore, if you do not come to your appointment and do not call our office that time is not filled.

- **Broken appointments result in a loss of valuable time. For this reason if you fail to keep the appointment a $40.00 charge will be incurred.**

- We utilize the most effective infection control measures and fully comply with the new State and Federal OSHA standards for sterilization. We maximize our use of disposable materials and autoclave all of our hand instruments.

Signature: _____ **Date:** _____

Financial Policy

Please be aware that the parent bringing the child to our office is responsible for payment of all charges.

1. **Payment is due in full** for each appointment as services are rendered. We accept cash, personal checks, MasterCard and Visa. ***A charge of $40.00 will be assessed on checks returned for any reason.***

2. **Pre-treatment Authorizations:** We will submit a pre-treatment estimate for all treatment prior to your child's restorative visit. Your pre-estimate will be explained to you and appointments will then be made. ***If you choose to have treatment done prior to having pre-determination returned from the insurance company, you will be responsible for all balances.***

3. **Fillings:** Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance company ***may not pay*** for a resin filling at the same level as silver (amalgam filling). ***The co-payment is your responsibility***. In some cases, the dentist may recommend placing a silver crown instead of a resin filling.

4. **Nitrous Oxide (Laughing Gas):** Nitrous oxide is not always covered by dental insurance. Payment will be required on the date of service.

5. **Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered. For emergency treatment by our office, outside of regular working hours there will be a $250.00 charge.

6. **Dental Insurance:** As a courtesy to our patients, our office will file an insurance claim with the primary insurance company. All ***secondary*** insurance must be filed by parent. Please be aware of your insurance policy benefits and limitations. Treatment is never based on insurance benefits but rather the best way to treat your child. Please remember, even if you have insurance coverage, you are responsible for non-covered services on the day of service. Please realize that your insurance coverage is a relationship between you, the insured patient, whom bears the ultimate financial responsibility, and your insurance company.

*** I, as the responsible party, acknowledge that a staff member has gone over all the above information with me and that I have read and understand my obligation completely.***

Signature: _____ Date: _____

I hereby consent to the taking of x-rays, photographs, and other necessary records before, during and after treatment and to use by this practice for scientific papers, demonstrations, lectures or our website.

Signature on file for consent: _____ Date: _____

I authorize the release to my insurance company or companies any information including diagnostic records and diagnosis of any treatment required to comply with applicable law and facilitate the billing and reimbursement for the treatment provided.

Signature on file for insurance: _____ Date: _____

I authorize Dr. Rene/Dr. Khakhria and staff to treat my minor child (under 18 years of age) without my presence in the office.

Signature for treatment of minor child: _____ Date: _____

ABOUT ICAT CBCT CONE BEAM SCANS

Jacaranda Orthodontics and Pediatric Dentistry now offers an exciting new technology for our patients and for patients of other doctors who might be referred here. This technology is called I-Cat Cone Beam Computer Assembled Tomography (CBCT) imaging, sometimes called 3-D radiographs or x-rays. Using CBCT means we now have the ability to take 3D images of the teeth, jaws, bones and facial structures at lower costs and with less energy than a typical CT scan used in hospitals. 3D imaging provides us the opportunity of improved diagnosis for our patients, especially in cases of impacted teeth, dental implants, surgical treatment, as well as more complex cases. Understandably you may have questions about exposure to these types of x-rays. Here are some facts you should know about 3-D imaging.

An ICAT CBCT exposure is:

- About 1/2 as much as a full series of digital dental images
- About 1/5 as much as a full (28) mouth series of standard dental x-rays
- About 1/70 as much as a typical medical CT scan

CBCT therefore offers our patients enhanced diagnostic value at a significantly reduced exposure. At the same time, CBCT scans can image the entire head and most of the neck. As dentists and orthodontists, we evaluate teeth, jaws and surrounding supporting bone, using CBCT's for those limited purposes.

Our training and dental license does not provide for evaluating and diagnosing outside those areas. However since CBCT imaging can cover a broader area, we want to offer you the opportunity to have your CBCT scan read by an oral radiologist, trained and licensed to evaluate and diagnose a broader area. CBCT may show evidence of disease of the cervical spine, skull or arteries. We can refer you to a radiology group for this purpose. The average cost is about $ $195.00. If you are interested in taking advantage of this service please initial the application section and sign the acknowledgement below.

( ) YES, I want to have my I-Cat CBCT scans read by an oral radiologist and understand I am responsible for the additional costs.

( ) NO, I understand the risks and benefits of having my CBCT read and interpreted by an oral radiologist, however I knowingly decline such a referral.

X_____ _____/_____/_____

Signature of patient/responsible party **Date**

All About Me!
Child's Questionnaire

We welcome you to our office!

Meet Dr. Khakhria:

- His first name is Milan, but everyone calls his Dr. Khakhria (Ka-Kria)
- He is married to Priti and has two children-Jaimin and Shail
- His favorite foods are shrimp  and anything **SPICY!** 
- In his spare time, he likes to cook, play soccer  , and likes to swim  and fish with his kids 
- He has a parrot named Leela 
- His favorite music is anything his children listen to 

Now tell him about **YOU**!

- The name or nickname I like to be called is _____
- I have ____ brothers and ____ sisters
- My favorite food is _____
- The sports I enjoy are _____
- The things I like about school are _____
- Do you have any pets? _____What kind? _____
- My favorite music is _____
- I think having braces would be _____
- Do you have any friends who come to our office? _____Their name(s) is/are _____
- Now tell us something special about you: _____

We are looking forward to meeting you in person!