GROWING SMILES
CHILDREN'S DENTISTRY
GURVEENA PARHAR D.D.S.
CERTIFIED, AMERICAN BOARD OF PEDIATRIC DENTISTRY

Date: _______________

Child's Name _____________________________________ Nickname _____________________

Child's Birthdate __________________________ Age __________ Sex: Male Female

Address ____

Home Phone ____________ Primary Cell Phone ____________ Email Address ________________

Have any of your other children ever been seen in this office? Yes No

Names and Ages of Brothers and Sisters ____

Tell us something about your child (favorite hobbies, pets, tv shows, etc.) ___________________________

____

WHO SHALL WE THANK FOR REFERRING YOU TO OUR OFFICE? _________________________

Please circle how you plan on handling your child's visit? Cash Check Visa MasterCard Discover

♦♦

Father's/Parent's Name _________________________ Address ______________________________

Father's/Parent's Employer ____

Father's/Parent's Employer's Address ____

Work Phone _____________ Cell Phone Number _____________ Social Security # ______________

Name & Address of Dental Insurance Company ____

ID# ____________________ Group Number _________________ Date of Birth ______________

♦♦

Mother's/Parent's Name _________________________ Address ______________________________

Mother's/Parent's Employer ____

Mother's/Parent's Employer's Address ____

Work Phone _____________ Cell Phone Number _____________ Social Security # ______________

Name & Address of Dental Insurance Company ____

ID# ____________________ Group Number _________________ Date of Birth ______________

MEDICAL HISTORY

Date of last medical exam: _____ Name of Physician: _____

Physician's Address and Phone #: _____

If you answer yes to any of these questions please give an explanation in the space provided at the end of this form.

Any learning, behavioral, excessive nervousness, or communication problems?	No ( ) Yes ( )
Were there any complications during pregnancy or was the child premature at birth?	No ( ) Yes ( )
Any problems with physical growth?	No ( ) Yes ( )
Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness?	No ( ) Yes ( )
Any sensory disorders? (Seeing, Hearing)	No ( ) Yes ( )
Any history of congenital heart disease, or heart damage from rheumatic fever?	No ( ) Yes ( )
Has any heart surgery been done or recommended?	No ( ) Yes ( )
Any history of chest pains or high blood pressure?	No ( ) Yes ( )
Any history of a heart murmur?	No ( ) Yes ( )
Has your child ever had a blood transfusion or blood products transfusion?	No ( ) Yes ( )
Any history of sickle cell disease?	No ( ) Yes ( )
Does your child bruise easily, have frequent nosebleeds, or bleed excessively from small cuts?	No ( ) Yes ( )
Has your child ever tested positive for HIV?	No ( ) Yes ( )
Has your child been diagnosed as being a hemophiliac?	No ( ) Yes ( )
Any history or pneumonia, cystic fibrosis, asthma, shortness of breath, or difficulty breathing? If yes, describe: _____	No ( ) Yes ( )
Any history of stomach, intestinal, or liver problems?	No ( ) Yes ( )
Any history of hepatitis or jaundice?	No ( ) Yes ( )
Any history of eating disorders, such as anorexia nervosa or bulimia?	No ( ) Yes ( )
Any unintentional weight loss?	No ( ) Yes ( )
Any history of urinary tract infections, bladder, or kidney problems?	No ( ) Yes ( )
Is the patient pregnant or possibly pregnant?	No ( ) Yes ( )
Any history of diabetes?	No ( ) Yes ( )
Any history of thyroid disorders or other glandular disorders?	No ( ) Yes ( )
Any history of skin problems?	No ( ) Yes ( )
Any history of cold sores (herpes) or canker sores (apathies)?	No ( ) Yes ( )
Any limitations of use of arms or legs?	No ( ) Yes ( )
Any arthritis or other joint problems?	No ( ) Yes ( )
Any problems with muscle weakness or muscular dystrophy?	No ( ) Yes ( )

Is your child allergic to any medications? If yes, please list,

_____ No ( ) Yes ( )

Any hay fever, skin rashes caused by allergies? No ( ) Yes ( )

Any other allergies? _____ No ( ) Yes ( )

Is your child currently taking medication (prescription or non-prescription)? No ( ) Yes ( )

Medication	Dosage	Times Per Day
_____	_____	_____
_____	_____	_____

Has your child ever received radiation therapy (x-ray treatments) or is it planned? No ( ) Yes ( )

Has your child ever received chemotherapy or is it planned? No ( ) Yes ( )

Has your child been hospitalized? No ( ) Yes ( )

Hospital (1) _____ (2) _____

Date _____ _____

Reason _____ _____

DENTAL HISTORY

Does your child have a toothache or any other immediate dental problem? No ( ) Yes ( )

Has your child ever had a toothache? No ( ) Yes ( )

Has your child ever had an injury to the mouth? No ( ) Yes ( )

Is this your child's first dental visit? No ( ) Yes ( )

If no: Date: _____ Dentist: _____

Reason: _____

Has your child ever had an unfavorable dental experience? No ( ) Yes ( )

Was your child nourished by nursing beyond the age of one? No ( ) Yes ( )

If yes, check: Breast _____ Nursing Bottle _____ Both _____ and to what age? _____

Does your child fail to eat a well-balanced diet? No ( ) Yes ( )

If yes, what foods or food groups are not adequate? _____ No ( ) Yes ( )

Does your child have any oral habits? If yes, please check: No ( ) Yes ( )

Thumb(s) _____ Finger(s) _____ Pacifier _____ Other _____

Does your child have difficulty opening his or her mouth, or does the child's jaw sometimes lock or stick in certain positions? No ( ) Yes ( )

Does your child have popping or clicking noises or pain during chewing or yawning? No ( ) Yes ( )

Does your child have frequent headaches or pain in or around the ears, eyes, or cheeks? No ( ) Yes ( )

DENTAL DISEASE INFORMATION

How often does your child brush? _____ time(s) per _____

Does your child use dental floss? No ( ) Yes ( )

Does someone assist your child with brushing and cleaning their teeth? No ( ) Yes ( )

Does your child use fluoride toothpaste? No ( ) Yes ( )

Has your child ever had a fluoride treatment? No ( ) Yes ( )

Has your child ever taken a fluoride supplement or vitamins with fluoride? No ( ) Yes ( )

Please note any special needs or comments we should know in order to better care for your child.

I understand that this information is necessary to provide me or my child with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

X Parent/Guardian Signature: _____ Date: _____

CONSENT: The undersigned hereby authorizes the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, mediation and therapy that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that the Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that the responsibility for payment for Dental Services provided in this office for the above mentioned patient is mine, due and payable at the time of service are rendered unless financial arrangements have been made in advance. I further understand that 1.5% finance charge (18% annually) will be added to my balance over 90 days. In the event of default, I promise to pay legal interest of the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

X Parent/Guardian Signature: _____ Date: _____

THE PARENT WHO BRINGS THE PATIENT IN FOR TREATMENT IS RESPONSIBLE FOR ALL FEES INCURRED AT THE TIME OF SERVICES ARE RENDERED.

CANCELATION POLICY: Although we know that unforeseen events and circumstances arise from time to time, it is important for patients to honor their appointments so that your doctor, our staff and other patients can rearrange their schedules. If you are unable to make your scheduled appointment, we request a minimum 24 hour cancellation notice. Therefore, our cancellation policy is that, upon your first cancellation in less than 24 hours of your scheduled appointment, we will inform you of our cancellation policy and no fees will be assessed as long as you reschedule your appointment promptly. After this, any cancellations made in less than 24 hours of the scheduled appointment will receive an assessed fee of $25 per 30 minutes that you have scheduled. As always, if you cancel 24 hours in advance by talking directly to our office staff (rather than leaving a voice mail), no fee will be charged.

I acknowledge that I have read, understand, and will abide by the Cancelation Policy provided above.

X Parent/Guardian Signature: _____ Date: _____

Growing Smiles Children's Dentistry

Redmond, Washington 98052

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Growing Smiles Children's Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Growing Smiles Children's Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature (if 18 years old or older): _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement of Privacy Practices**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	