New Patient Information and Health History

Today's Date ____________________________________

Section 1: Tell Us About Your Child

Child's Full Name ________________________________
Preferred Name __________________________________
❑ Male ❑ Female SS#__________________________
Child's Birthdate _____/_____/_____ Age__________
School ____
Home Address ____________________________________
City _______________________ State________ Zip_____

Section 2: Parent/Guardian Contact Information

Name ____
❑ Parent ❑Stepparent ❑ Legal Guardian
Best Contact Number ______________________________
Alternative Number ______________________________
Email ____
What is your appointment confirmation preference (please check all that apply)
❑ Text ❑ Phone ❑Email

Section 3: Responsible Person For Payment

Name____
❑ Parent ❑Stepparent ❑ Legal Guardian
Phone # ____
Phone # ____
Home Address ____________________________________
City _______________________ State________ Zip_____
Birthdate _____/_____/_____ SSN _________________
Employer____
Insurance Co. Name ______________________________
Insurance Phone _________________________________
Insurance Identification # _______________________

Secondary Dental Insurance (if applicable)
Insurance Co. Name_______________________________
Insurance Phone _________________________________
Insurance Identification # _______________________

Additional Information ___________________________
____
____
____

Section 4: How Did You Hear About Us?

❑ Family/Friend ❑ Google/Search ❑ Insurance
❑ Social Media ❑ Advertisement ❑ Physician
❑ Reviews ❑ Healthystart ❑ Dawson
Referral Source ___________________________________

Section 5: Accompanying Your Child

A parent or legal guardian must be present during appointments.

Please list any person(s), other than legal parents/ guardians, who are authorized to accompany your child to any routine dental visits
Name____
Relation____
Name____
Relation____
Authorized person(s) must present ID upon arrival
❑ None; only legal parents/guardians may accompany

Section 7: Dental History

Please tell us the reason for today's visit.
❑ First visit to dentist ❑ Change of dental care
❑ Emergency ❑ Other
____

If not the first visit, when did they see a dentist prior?
Date ____
Dentist ____
Address____
Were X-Rays taken? ❑ Yes ❑ No
Have there been any injuries to the teeth, face, or mouth?
❑ Yes ❑ No If yes, please explain
____
____

Has your child had any pain or tenderness in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does your child have any of the following habits/concerns?

❑ Thumb/Finger Sucking ❑ Mouth Breathing
❑ Lip Sucking/Biting ❑ Nail Biting
❑ Nursing/Bottle Habits ❑ Pacifier Use
❑ Tooth Grinding ❑ Snoring
❑ Other____

Childs Name ____

Section 7: Dental History cont.

Has your child ever had a serious or difficult problem associated with dental work or a dental visit? ❑ Yes ❑ No
If Yes, please explain ______________________________
____

Does your child brush his/her teeth daily? ❑ Yes ❑ No
Does your child floss his/her teeth daily? ❑ Yes ❑ No

Section 8: Health History

- ❑ ADD/ADHD
- ❑ AIDS/HIV+
- ❑ Allergies
- ❑ Asthma
- ❑ Autism
- ❑ Blood Disorders
- ❑ Bone/Muscular Disorders
- ❑ Cancer
- ❑ Congenital Birth Defects
- ❑ Convulsion/Epilepsy
- ❑ Depression/Anxiety
- ❑ Diabetes
- ❑ Disability/Special Needs
- ❑ Eating Disorder
- ❑ Hearing Impairment
- ❑ Heart Disease/Murmur
- ❑ Hepatitis
- ❑ Hospital Stays
- ❑ Immune Disorders
- ❑ Kidney/Liver Condition
- ❑ Rheumatic/Scarlet Fever
- ❑ Tuberculosis
- ❑ Visual Impairment
- ❑ Other____________
- ❑ None of the above

Please provide us with details regarding any medical conditions your child may have.

Medical conditions ______________________________
____
____

List all medications your child is taking ❑ None
____
____
____

List all allergies (drugs, latex, etc.) ❑ None
____
____

Any other concerns ______________________________
____
____
____
____

Childs Primary Care Physician ______________________
____

Office Address __________________________________
____

City ______________________ State______ Zip_________
Phone Number __________________________________

Section 9: Are You On Social Media?

If your child participates in our contests, awards, fun signs, celebrations and or photo booths we'd love to share photos with our friends and family!
So that our friends can like and share in your child's experiences at our office, do we have your permission to use your child's picture on our social media pages? Photos may be displayed on Facebook, Instagram, Website and in the office on display boards.
❑ Yes ❑ No

Section 9: HIPAA

The privacy of your health information is very important To us and our practice follows all HIPAA regulations. Notice of our HIPAA Privacy Practices with complete details have been made available to you and a copy of our HIPAA guidelines is available online for you to Review or you may request a hard copy from us.

Please initial below to acknowledge that you have read and understand our HIPAA Privacy Practice Notice.
________ I have carefully read this office's Notice of Privacy Practices.
________ I understand that I am entitled to receive a paper copy of this office's Notice of Privacy Practice upon request.

Section 10: Authorization To Treat

Our office is committed to meeting and exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff at Dental Buddies of Vero Beach to perform the necessary dental services my child may need based on our treatment plan.

____
Parent/Guardian Name

____
Parent/Guardian Signature

Date ____

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Dear Parent,
As part of the comprehensive services provided at Dental Buddies and Dental Partners we are asking all patients to include a Healthy Start Sleep Disordered Breathing Questionnaire with their Health History. This questionnaire will give us an overall evaluation of your child's sleeping patterns and patterns of their daily living. Studies show that an estimated 9 out of 10 children suffer from sleep disordered breathing, interrupted sleep, that leads to numerous health concerns. Our goal is to assist our patients through diagnosis and a treatment plan that if instituted will provide long-term health benefits. We look forward to reviewing this evaluation with you. Thank you.

Today's date: ______________________________
Patient: ______________________________ DOB: ______________________ Age: __________
Completed by: ______________________________ Relation to patient: ______________________________

Sleep Disordered Breathing Questionnaire For Children

Please indicate to what degree your child exhibits any of the following symptoms using the scale of severity below. The initial score column should be evaluated and dated at the first appointment with us and the follow-up score column should be evaluated and dated, after 3 months of treatment, by the same person who completed the initial assessment.

Not Present: 0 Very Mild: 1 Mild: 2 Moderate: 3 Pronounced: 4 Severe: 5

#	Initial Score	Follow-Up Score	Symptom
1.	_____	_____	Snoring of any kind
2.	_____	_____	Snores infrequently (1 night per week)
3.	_____	_____	Snores often (2-4 nights per week)
4.	_____	_____	Snores habitually (5-7 nights per week)
5.	_____	_____	Has labored, difficult, loud breathing at night
6.	_____	_____	Has interrupted snoring, breathing stops for more than 4 or more seconds
7.	_____	_____	Has stoppage of breathing more than 2 times in an hour
8.	_____	_____	Hyperactive
9.	_____	_____	Mouth breathes during the day
10.	_____	_____	Mouth breathes while sleeping
11.	_____	_____	Frequent headaches in the morning
12.	_____	_____	Allergy symptoms *(please check all that apply)* ❑ Asthma ❑ Eczema ❑ Nasal congestion Other__________________________
13.	_____	_____	Excessive sweating
14.	_____	_____	Talks in sleep
15.	_____	_____	Poor ability in school *(please check all that apply)* ❑ Math ❑ Science ❑ Spelling ❑ Writing ❑ Reading ❑ Other
16.	_____	_____	Falls asleep watching TV
17.	_____	_____	Wakes up at night
18.	_____	_____	Attention deficit
19.	_____	_____	Restless sleep
20.	_____	_____	Grinds teeth
21.	_____	_____	Frequent throat infections
22.	_____	_____	Frequent ear infections
23.	_____	_____	Feels sleepy and /or irritable during the day
24.	_____	_____	Difficult time listening and often interrupts
25.	_____	_____	Fidgets with hands and does not sit quietly *(please check all that apply)* ❑ Muscular tics ❑ Restless (wiggles) legs
26.	_____	_____	Wets bed
27.	_____	_____	Blush color at night or during the day
28.	_____	_____	Nightmares and/or night terrors
29.	_____	_____	Exhibits any of the following *(please check all that apply)* ❑ Rarely smiles ❑ Feels sad ❑ Feels depressed
30.	_____	_____	**Speech Problems**

If scored greater than 0 for Speech Problems please continue to the 2nd page of the Healthy Start Questionnaire.

Questionnaire information provided by Healthystart®

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If you answered that you feel your child has a speech delay or problem on the first page of this questionnaire please complete the following questions to the best of your ability.
We look forward to reviewing this evaluation with you. Thank you.

Today's date: ___________________________________
Patient: ____
DOB: ___________________________ Age:__________
Completed by: __________________________________
Relation to patient: ______________________________

Speech Questionnaire Further Speech Assessment For Children

Not Present: 0 Very Mild: 1 Mild: 2 Moderate: 3 Pronounced: 4 Severe: 5

Initial Score | Follow-Up Score

1. _____ _____ Do you or others have difficulty understanding your child's speech?
2. _____ _____ Is it difficult to understand the child over the phone?
3. _____ _____ Does the child use grunts or screams more than words?
4. _____ _____ Lisp?
5. _____ _____ Hoarseness?
6. _____ _____ Nasal speech?
7. _____ _____ Has frustration when attempting to speak?
8. _____ _____ Often uses words with only 1 or 2 syllables?
9. _____ _____ Seems winded when increases volume?
10. _____ _____ Any difficulty in swallowing?
11. _____ _____ Do you think your child has a stutter?
    _____ _____ Any family history of a stutter? Y/N
12. _____ _____ Tourette's syndrome?
13. _____ _____ Family history of a speech or language disorder?
14. _____ _____ Any speech therapy?
    If so for how long? ____________

Specific Articulate Questions

Not Present: 0 Very Mild: 1 Mild: 2 Moderate: 3 Pronounced: 4 Severe: 5

Does your child present with any of the following speech patterns?

1. _____ _____ hap for hat, kif for kiss, fum for thumb, or bav for bath
   Child replaces a t, d, n, s, z, th, with a p, b, m, w, f, or v
2. _____ _____ wabbit for rabbit, yewo for yellow, weg for leg, pway for play, wun for run
   Child replaces an r with a w or an L with a w or a y
3. _____ _____ tock for sock, dumb for jump, pan for fan, bat for fat
   Child replaces a s, f, v, z, th, j, or h with a consonant such as p, b, t, d, k, g
4. _____ _____ Sum for thum, muhzer for mother
   Child replaces a p, b, m, w, th, f, or v with a t, d, s, z, n, or L
5. _____ _____ gog for dog, cop for top, boke for for boat, key for tea
   Child replaces a t or a d with k or g
6. _____ _____ ship for chip, shoo shoo for choo choo
   Child replaces a ch or a j sound with a sh, v, f, th, or s
7. _____ _____ pasghetti for spaghetti, efelant fot elephant, baksit for basket
   Child changes position of a sound within a word
8. _____ _____ Stuh-reet for street, fuh-wong for frog, buh-lue for blue, puh-lease for please
   Child inserts uh into words
9. _____ _____ Doat for goat, tuhtie for cookie, tuo for cup, hud for hug
   Child replaces a k or a g with a t or d
10. _____ _____ Sue for shoe, sip for ship, Mezza for measure
    Child replaces a sh with a s

Questionnaire information provided by Healthystart®