LEFCOE, WEINSTEIN, SACHS, SCHIFF & ASSOCIATES
FAMILY DENTISTRY

PERSONAL, MEDICAL AND DENTAL HISTORY

We are continually concerned with your health and the care that is rendered to you. It is therefore important to update this information on a yearly basis. If you have any questions, please feel free to ask one of our staff members to assist you. Please print clearly.

PATIENT INFORMATION

Date _____

Name of Minor/Child _____
First M.I. Last

Sex: ___M ___F Age_____ Birthdate_____ Nickname_____

Home Address _____
Street City State Zip

Child's S.S. #_____ Whom may we thank for referring you? _____

RESPONSIBLE PARTIES / INSURANCE INFORMATION

Father's/Guardian's Name_____

Address (if different from patient's) _____

_____

Home Phone_____ Work Phone_____

Cell Phone _____

Employer _____
RANK/RATE

Employer Address _____
How long employed

City, State, Zip_____

Union or Local _____

S.S.#_____ **BIRTHDATE** _____

Do you have dental insurance coverage for minor/child? ___Yes___No

Insurance Co. _____

Group #_____ Policy ID # _____

Ins. Co. Address _____

City, State, Zip_____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone_____ Work Phone_____

Cell Phone _____

Employer _____
RANK/RATE

Employer Address _____
How long employed

City, State, Zip_____

Union or Local _____

S.S.#_____ **BIRTHDATE** _____

Do you have dental insurance coverage for minor/child? ___Yes___No

Insurance Co. _____

Group #_____ Policy ID # _____

Ins. Co. Address _____

City, State, Zip_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household, a relative or friend.)

Name_____ Relationship _____

Address _____
Street City State Zip

Home Phone_____ Work Phone _____

AUTHORIZATION

I authorize the following person(s) to bring my child in for appointments and approve doctor recommended treatment.
I also give this practice my permission to release the doctor's recommended future treatment to said authorized person(s):

Name _____ # _____

Name _____ # _____

Name _____ # _____

I, _____ , have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that by signing this section, I am giving my consent to your use and disclosure of my child's PHI to carry out treatment, payment activities and health care operations.

Signature: _____

DENTAL/MEDICAL HEALTH HISTORY (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient ID # _____

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated?	☐ Yes	☐ No
Does your child take fluoride supplements?	☐ Yes	☐ No
Does your child:		
Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew hard objects (pencils, etc.)	☐ Yes	☐ No
Grind teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of last dental visit _____

Previous Dentist _____

Address _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Has your child ever had any of the following:

Asthma	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses — When?

_____ _____

_____ _____

Is your child taking any medications? ☐ Yes ☐ No (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

_____

FINANCIAL ARRANGEMENTS: Payment in full is expected at each appointment. For your convenience, we offer the following methods of payment:

○ Cash ○ Personal Check ○ Charge Cards

I hereby apply for treatment by the above dentists, their associates and/or assistants. Treatment may include x-rays, injections and/or such other office procedures they deem necessary.

If health care workers are accidently exposed to my blood or body fluids in the course of providing health care to me, I agree to have my blood tested for any infectious disease which might be transmitted to them through this exposure, including HIV/AIDS and hepatitis.

Payment policies of Drs. Lefcoe, Weinstein, Sachs and Schiff have been explained to me, and I hereby acknowledge and accept responsiblity for payment of all charges incurred with the above dentists, acknowledging that they may obtain a credit report in order to establish credit.

It is understood that this responsibility extends to the total charges without regard to possible insurance benefits, and that any insurance benefits which may be provided will be considered part of my financial resource only and will not waive my responsibility. If payment for such medical services is not made when due, the undersigned agrees to pay all costs of collecting the medical bill, including 33 1/3% attorneys' fees and costs, skip tracing and third party services. I have read and fully understand the meaning and consequences of the above statement. INTEREST RATE: 1½% PER MONTH (Equivalent 18% APR) on that part of accounts due over 60 days (Minimum interest rate $.50).

PATIENTS WITHOUT INSURANCE - PAYMENT IS DUE AT THE TIME OF THE VISIT

A charge of $25.00 will be made for appointments broken or cancelled without 24 hour notice. A charge of $25.00 will be made for returned checks.

PATIENT_____**RESPONSIBLE PARTY** _____

DATE_____

LEFCOE, WEINSTEIN, SACHS, SCHIFF & ASSOCIATES
FAMILY DENTISTRY, ORTHODONTICS & DENTISTRY FOR CHILDREN

ADDITIONAL DENTAL/MEDICAL HEALTH INFORMATION (Confidential) **Date** _____

Medical History

Heart murmur or Mitral valve prolapse	___ yes ___ no	Crohn's disease	___ yes ___ no
Stomach problems	___ yes ___ no	Learning disorder	___ yes ___ no
Congenital heart disease	___ yes ___ no	Autism	___ yes ___ no
Hypoglycemia	___ yes ___ no	ADHD/ADD	___ yes ___ no
Thyroid condition	___ yes ___ no	Speech/ language delay	___ yes ___ no
History of transplant	___ yes ___ no	Psychological disorder	___ yes ___ no
Anemia	___ yes ___ no	Cleft lip only ___ Cleft palate only ___	
Endocrine disorder	___ yes ___ no	Cleft lip and palate ___	
GERD (gastro esophageal reflux disorder)	___ yes ___ no	Repair/reconstruction surgery?	___ yes ___ no
Radiation therapy	___ yes ___ no	Other medical problems_____	
Headaches	___ yes ___ no	_____	

My child needs antibiotic prophylaxis prior to dental treatment: ___ yes ____ no

Medications: ___ none

_____

Surgeries ___ none

_____

Allergies

Food allergies: ___ none, or

_____

Personal or family history of **Malignant Hyperthermia** (allergy to general anesthesia): ___ yes ___ no

Immunization History

Child has had the following immunization: (please check all that apply)

___ Diphtheria, Tetanus, Pertussis (DTP) 2, 4, 6, 15-18 months old, and 4 years old to 7th birthday

___ Haemophilus Influenzae b (HbCV) 2, 4, 6, 15 months

___ Polio (OPV) 2, 4, 15-18 months old, and 4-6 years old

___ Measles, Mumps, Rubella (MMR) 11-12 years old

___ Adult Tetanus and Diphtheria (Td) 14-16 years old, repeated every 10 years

Birth History

Patient was born at _____ weeks gestation

Pregnancy abnormalities: _____

Birth abnormalities / congenital defects: _____, or _____

Please circle: Vaginal delivery / Planned caesarean section / Unplanned caesarean section

Patient was intubated: ___ yes ___ no

Patient was hospitalized: ___ yes ___ no *If yes, for how long?*

Family Information

Siblings name	Gender	Age	Lives in same home?	Patient of LWSS?

Dietary History

Breast-fed until age _____ Bottle-fed until _____ Sippy cup until age _____

Child slept with milk or juice bottle: ___ yes ___ no until age: _____

Started regular cup age: _____

Please detail dietary restrictions:

_____

Dental Health History

Child's water supply is primary: town/city of _____ *fluoridated?* ___ yes ___ no, or well-water ___

Child's oral homecare is: _____ assisted, *or* _____ supervised, *or* ____ unsupervised

Does this child have an immediate dental problem? *(please describe):* _____

_____

_____

History of toothache: ____ yes ___ no

Describe: _____

History of injury to mouth, teeth, jaws?: ___ yes ___ no

When: _____

Please describe the injury:

_____

Please check previous dental care: _____ x-rays _____ cleaning / fluoride _____ exam _____ filling ____ extraction

Child's attitude at last dental visit (other provider) was: ____ undisturbed ____ nervous _____ anxious _____ panicky

History of dental treatment under sedation? ___ yes ___ no; under general anesthesia? ___ yes ___ no

History of orthodontic care (appliances, braces)? ___ yes ___ no, with Dr. _____

When? _____

TMJ (please check all that apply): _____ clicking _____ popping _____ locking ____ tenderness ____ no known problems

LEFCOE, WEINSTEIN, SACHS & SCHIFF
FAMILY DENTISTRY

CONSENT TO BEHAVIOR MANAGEMENT

We do our best to give your child the best quality dental care in a safe and caring environment.

Every effort will be made to work with your child to gain cooperation through understanding, gentle guidance, humor and charm. When these fail there are other management techniques that can eliminate or minimize disruptive behavior. Our dentist(s) and staff have received training in the following techniques accepted by the American Academy of Pediatric Dentistry:

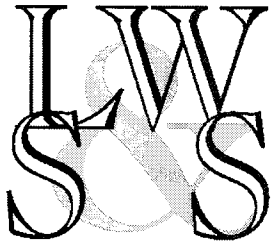
- **Tell-show-do** - the dentist or staff member explains to the child what is to be done, shows an example on a tooth model or on the child s finger, then the procedure is done on the child s tooth.
- **Positive reinforcement** - rewards the child who displays cooperative behavior with complements, praise, a pat on the shoulder or a small prize.
- **Voice control** - the attention of a disruptive child is redirected by a change in the tone and volume of the dentist s voice.
- **Mouth props** - a padded device is placed in the mouth to prevent closure of the child s teeth on the dentist s fingers or dental equipment.
- **Hand and/or head holding by a dentist or assistant** - an adult keeps the child s body still so the child cannot grab the dentist s hand or sharp dental tools.
- **Nitrous Oxide** - medication breathed through a colored/flavored nose mask to relax a nervous child. The child remains awake but is relaxed and calm. Nitrous oxide is also known as *laughing gas*. Children with sensitive stomachs may become nauseated when breathing nitrous oxide and patients are asked not to eat three hours prior to the appointment.
- **Stabilization wrap** - a body wrap made of fabric mesh and Velcro that is placed around the child to limit movement. It is never used without the consent of the parent prior to immediate use.

_____

Parent/Guardian

_____

Witness



LEFCOE, WEINSTEIN, SACHS & SCHIFF
FAMILY DENTISTRY, ORTHODONTICS
&
DENTISTRY FOR CHILDREN

DUE TO THE INCREASE IN INSURANCE COST AND THE NEVER ENDING CHANGES TO INSURANCE COVERAGE, IT IS THE PATIENT/PARENT S RESPONSIBILITY TO KNOW WHAT THEIR INSURANCE DOES AND DOES NOT COVER.

X-RAYS AND FLUORIDE

X-rays and fluoride are a very important part of routine cleanings. X-rays detect much more than cavities. X-rays may be needed to survey erupting teeth, diagnose bone disease, evaluate the results of an injury, or plan orthodontic treatment. X-rays allow dentists to diagnose and treat conditions that cannot be detected during a clinical examination. Fluoride is a vitamin for the teeth to help prevent tooth decay. It is an important part in helping keep a healthy smile.

Insurance usually covers bitewing x-rays once a year and a panorex once every three years. Depending on the insurance, fluoride could be covered twice a year, but the majority only covers it once a year. New patients need to be aware that if x-rays and fluoride were done at another dental office within the last year, the insurance may not cover them if taken in our office and the patient/parent will be responsible for the balance.

Your signature below acknowledges that you have been made aware that insurance may not cover these procedures. You also understand that it is your responsibility to let the office know if there is a chance x-rays and fluoride were done in another dental office.

_____ _____

Signature Date