Dickson Pediatric Dentistry, PLLC.

Patient Medical Update

PATIENT INFORMATION

First Name		MI		Last Name		Birth Date			
Address		City		State		ZIP			
Parent/Guardian Email		Cell Phone							
Emergency Contact *(other than parent)*									
First Name		Last Name		Cell Phone					

HEALTH HISTORY

Has your child ever had any of the following conditions?

	YES	NO		YES	NO		YES	NO
Asthma			Thyroid Problems			Anxiety		
Snores			Diabetes			Epilepsy		
Sleep Apnea			Acid Reflux			Seizures		
Cancer			Autism			Migraines		
Hepatitis			Developmental Delay			Heart Murmur		
Abnormal Bleeding			ADHD or ADD			Heart Defect		
Hemophilia			Disabilities			Rheumatic Fever		
HIV or AIDS			Other			If yes, please list		
Emergency Room Visit			If yes, what for?					
Previous Surgeries			If yes, what?					

MEDICATIONS

Please list all medications, over the counter & herbal supplements that the child is currently taking:

ALLERGIES

Is the child allergic to, or had any reaction to any of the following?

	YES	NO		YES	NO		YES	NO
Zithromax			Clindamycin			Cillins		
Sulfa Drugs			Latex			Nuts		
Red Dye								

Please list any allergy/ reaction to food, medications, or the environment that is not listed above:

FORM COMPLETION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in 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.

Signature of Parent or Legal Guardian		Date	
Printed Name		Relationship	

Dickson Pediatric Dentistry, PLLC.

HIPAA Acknowledgment

PATIENT INFORMATION					
First Name		**Last Name**		**Birth Date**	

Acknowledgment of Receipt of Notice of Privacy Policies

Your Privacy Is Important To Us

Please click on the hyperlink to obtain a copy: *Notice of Privacy Practices*

I have been given the opportunity to view a copy of the Notice of Privacy Practices of Dickson Pediatric Dentistry, PLLC and I am aware that it is posted on site. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as well as my dependent's, as authorized in the Patient Consent Form.

Authorization for Personal Health Information

Please list authorized person with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____
   Printed Name — Relationship to Patient

2. _____
   Printed Name — Relationship to Patient

3. _____
   Printed Name — Relationship to Patient

4. _____
   Printed Name — Relationship to Patient

In my ABSENCE I hereby authorize the above person/people to accompany my child/children for necessary preventative and/or restorative appointments to Dickson Pediatric Dentistry, PLLC as deemed by Dr. John Stritikus, Dr. Justin Robbins, their associates and DPD PLLC staff. These procedures could include photographs, x-rays, fluoride treatments, nitrous oxide, possibly even sedation medications. As witnessed by my signature, I will indemnify and hold harmless Dr. John Stritikus, Dr. Justin Robbins, their associates and DPD PLLC staff, for all claims arising out of my consent for my child to be treated.

FORM COMPLETION			
Signature of Parent or Legal Guardian		**Date**	
Printed Name		**Relationship to Patient**	