Tiny Texans Pediatric Dentistry

Christina R. Ramirez, D.D.S

PATIENT HISTORY

In order to ensure your/your child's safety, comfort and happiness during dental treatment, we need to obtain information from you. Please carefully and completely answer the questions below. Thanks!

PRINT:

Patient's Name_____Nickname (if any) _____
First Middle Last

Date of Birth_____ Age_____ Sex: M F
Month Day Year

Attends what school? _____Grade_____

Interests or hobbies_____

How did you find out about our office?

☐ Referred by physician/dentist ☐ Referred by friend ☐ Insurance ☐ Google ☐ Yelp ☐ Nextdoor App

☐ Facebook ☐ Live nearby/drive by ☐ school or neighborhood event ☐ Other_____

Whom may we thank for referring you to our office? Name_____

PATIENT DENTAL HISTORY

What is your chief concern for this appointment? _____
_____

Is this the patient's first visit to a dentist? Yes No
If not, how long since the last dental visit? _____

Previous dentist:
Name_____
Phone# _____

Any history of dental trauma? Yes No
If so, please explain: _____

Does the patient currently have any dental pain or have they ever had any major dental problems in the past? Yes No
If so, please explain_____

Has the patient ever had an unpleasant dental experience? Yes No
If so, please explain_____

When recommended by Dr. Christina R. Ramirez, I approve use of:
fluoride on my child? Yes No **Initial** _____
dental radiographs (x-rays)? Yes No **Initial** _____

FAMILY DENTAL HISTORY

Do any dental problems run in your family? Yes No
If so, please explain _____

CAVITY PREVENTION HISTORY

Does the patient receive fluoride daily?
Yes We have it in our water
Yes We use fluoride toothpaste, rinse or gel
No We prefer not to expose our child to fluoride at this time

Does the patient …
drink milk, soda, or juice throughout the day? Yes No
drink milk, soda, or juice before bed? Yes No
often eat sticky snacks like gummy fruit snacks? Yes No
take gummy vitamins on a daily basis? Yes No

How often are patient's teeth brushed daily? 1 2 More Less
Who brushes the patient's teeth? Child Parent We Take Turns
Is the patient familiar with dental floss? Yes No

GROWTH AND DEVELOPMENT

Does the patient have a bite problem? Yes No
Does the patient have a speech problem? Yes No
Does the patient have any oral habits such as sucking a thumb, finger, pacifier, lip, grinding, etc.? Yes No
(*Circle All That Apply)*

PATIENT MEDICAL HISTORY

Primary Care Physician:
Name_____

Is the patient currently under a physician's care for any reason other than routine visits? Yes No
If so, please explain_____

Has the patient had any surgery or serious illness? Yes No
If so, please explain_____

Is any future surgery/medical treatment planned at this time? Yes No
If so, please explain_____

Has the patient had any history of:

Seasonal Allergies (pollen, cedar, etc.)	Yes	No
Heart Trouble or Heart Murmur	Yes	No
ADHD/ADD	Yes	No
Autism or Asperger Syndrome/spectrum	Yes	No
Diabetes	Yes	No
Tuberculosis	Yes	No
Kidney or Liver Disease	Yes	No
Epilepsy/Nervous System Disorder/Seizures	Yes	No
Rheumatic Fever	Yes	No
Cerebral Palsy	Yes	No
Asthma or Lung Problems	Yes	No
Bleeding Trouble or Blood Disorder	Yes	No
AIDS or HIV	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Radiation Treatment	Yes	No
Sickle Cell Anemia	Yes	No
Anemia	Yes	No
Arthritis	Yes	No
Slow Learner/Delayed Development	Yes	No
Complication w/ Nitrous Oxide	Yes	No
Complication w/ Local Anesthesia	Yes	No

Does the patient have any mental, emotional, or physical delay or condition? Yes No
If so, please describe_____

Is the patient allergic to any medications, foods, or latex? Yes No
If so, please list_____

Is the patient currently taking any medications? Yes No
Please list and if taken in AM or PM? _____
_____

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ONE PER FAMILY: Complete the Responsible Person/Legal Guardian Information **Date _____**

Responsible Person #1:

Name_____ DOB: _____

Relationship to Patient □ Parent □ Legal Guardian □ Step-Parent □ Grandparent □ Other _____

Marital Status □ Single □ Married □ Separated □ Divorced □ Partner

Home Address Street_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email_____

Occupation_____ Employer_____

Responsible Person #2:

Name_____ DOB: _____

Relationship to Patient □ Parent □ Legal Guardian □ Step-Parent □ Grandparent □ Other _____

Marital Status □ Single □ Married □ Separated □ Divorced □ Partner

Home Address Street_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email_____

Occupation_____ Employer_____

Our office uses a text confirmation service, who should we contact first about the patient's dental appointments?

Name: _____ Cell Phone #: _____

Appointment Schedule Policy – No Show and Saturday Appointments: We understand schedules change and you may not be able to keep your appointment. If you are unable to keep your scheduled appointment, please call us 24 hours in advance. Failure to do so will result in a $25 cancellation fee per appointment. If you miss two appointments without proper notification, we reserve the right to dismiss the patient from care. Saturday is available by appointment only and requires a 48-hour cancellation notice. These days are in high demand and if notice is not provided, it forfeits future Saturday appointments. **Initial _____**

Appointment Authorization: Please list all authorized persons who you authorize to bring your child/children to their dental appointment. We will also require a six-month medical update form to be completed at your child's appointment, thus making the person bringing your child to the appointment responsible for any medical changes, current medications and dental concerns. If your child is coming to his/her appointment on their own, arrangements to have a parent complete the six-month medical update form will have to be made prior to the appointment. A person under the age of 18 years old cannot fill out the medical update form.

Child/Children's Name(s) _____

Authorized Persons

1._____ Relationship_____

2._____ Relationship_____

3._____ Relationship_____

Permission is hereby granted to the doctor and staff to perform an initial dental examination and treatment which may include preventive education, x-rays, dental cleaning, and fluoride treatment. *(Note: Some insurance plans may not cover some procedures due to age/frequency limitations. Our office gives you an estimate of charges for treatment appointments; actual charges may differ due to conditions found during treatment. Please remember we accept insurance assignment as a courtesy to you. If your insurance company pays less than the estimated amount or does not pay within 60 days you will be billed for the balance.)* I understand and give consent for treatment.

Signature_____Date_____

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NOTICE OF ELECTRONIC DISCLOSURE OF PROTECTED HEALTH INFORMATION ACKNOWLEDGEMENT

If we obtain or create information about your health, we are required by law to protect the privacy of your information. Protected Health Information (PHI) includes any information that relates to:

- Your past, present, or future physical or mental health or condition;
- Health care provided to you; and
- Past, present, or future payment for your health care.

We may not disclose your PHI electronically without your authorization unless allowed by law. For example, we may share your PHI though approved, severe electronic methods for the purpose of treatment, payment for healthcare services, or health care operations such as case management or care coordination. We may also need to share your PHI electronically for public health purposes such as preventing and controlling the spread of infectious diseases or for certain disaster relief efforts. For a complete list of reasons that we are allowed by law to share your PHI, please refer to our Notice of Health Information Privacy Practices.

I give my consent to Tiny Texans Pediatric Dentistry to send text message reminders to my cell phone through a secure phone service, I understand that they are transmitted over a public network onto a personal telephone and as such may not be secure. However, the practice will not transmit any information which would enable an individual patient to be identified. These messages will be a reminder of a previously booked appointment date and time, or a notification that I need to schedule an appointment.

If you believe that we have violated the obligations described in this notice, you have the right to file a complaint to the Privacy Officer at: 11200 Manchaca Rd, Bldg 4, Ste 1, Austin, TX 78748.

I, _____, have reviewed this office's Notice of Privacy Practices. I was also given the option to request a copy for my own records.

_____ _____

(Signature) (Date)

PATIENT PHOTO RELEASE ACKNOWLEDGEMENT

Patient Name(s): _____ _____

_____ _____

[ ] I, _____ give permission for Tiny Texans Pediatric Dentistry to display my or my child's photograph on their office website or other social media sites.
Please visit our website at www.tinytexanspediatricdentistry.com or www.facebook.com/tinytexans to view your pictures.

Do you have a preference for you/your child's name listing?

[ ] First Name Only
[ ] First Initial and Last Name
[ ] Picture Only – NO Name

[ ] I prefer not to have my child's picture displayed on the office website/Facebook.