Tiny Teeth
Kids' Dentistry & Orthodontics

CHOICE HEALTHCARE SERVICES AFFILIATE

PATIENT INFORMATION

NAME: LAST _____ FIRST _____ MI _____ GENDER: M F

BIRTH DATE _____/_____/_____ AGE _____ SS# _____-_____-_____

HOME PHONE _____CELL _____ OTHER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DENTAL & MEDICAL HISTORY

IT IS CRUCIAL THAT ANY DENTAL AND MEDICAL HISTORY PROVIDED IS CURRENT

PREVIOUS DENTAL OFFICE _____ LAST DENTAL VISIT _____ X-RAYS TAKEN? Y N

(PLEASE CIRCLE THOSE THAT APPLY)

DOES YOUR CHILD HAVE PERIODONTAL (GUM) PROBLEMS? YES NO

DO YOU FEEL YOUR CHILDS GUMS BLEED, FEEL IRRITATED, OR TENDER? YES NO

DOES YOUR CHILD FLOSS REGULARLY? YES NO

HAS YOUR CHILD HAD ANY PROBLEMS ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? YES NO

IS YOUR HOME WATER SUPPLY FLUORIDATED? YES NO

DOES YOUR CHILD DRINK BOTTLED OR FILTERED WATER FREQUENTLY? YES NO
IF YES, HOW OFTEN? DAILY / WEEKLY / OCCASIONALLY (PLEASE CIRCLE THOSE THAT APPLY)

HAS YOUR CHILD HAD ORTHODONTIC (BRACES) TREATMENT? YES NO

DOES YOUR CHILD EXPERIENCE HEADACHES, EARACHES, OR NECK PAIN? YES NO

ARE YOUR CHILDS TEETH SENSITIVE TO HOT / COLD / PRESSURE / SWEETS? YES NO
(PLEASE CIRCLE THOSE THAT APPLY)

IS YOUR CHILD HAPPY WITH THE APPEARANCE OF THEIR TEETH? YES NO

DENTAL CONCERNS _____

PRIMARY PHYSICIAN INFORMATION:

IS YOUR CHILD UNDER THE CARE OF A PHYSICIAN? YES NO

PHYSICIAN NAME _____ PHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF LAST PHYSICAL EXAM _____

IS YOUR CHILD TAKING ANY MEDICATIONS? YES NO
LIST MEDICATIONS _____

HAS YOUR CHILD BEEN HOSPITALIZED OR HAD SURGERY? YES NO
PLEASE EXPLAIN _____

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CONDITIONS

Does your child have, or has your child had, any of the following?

- ☐ Cancer or Tumor
- ☐ Heart Murmur, Mitral Valve Prolapse, Heart Defect
- ☐ Rheumatic Fever
- ☐ High / Low Blood Pressure
- ☐ Tuberculosis or other lung problems
- ☐ Kidney Disease
- ☐ Hepatitis or other liver disease
- ☐ Blood Transfusions; Date of last transfusion _____
- ☐ Diabetes
- ☐ Epilepsy, seizures, or fainting spells
- ☐ Arthritis
- ☐ Herpes or cold sores
- ☐ AIDS or HIV positive
- ☐ Migraine headaches or frequent headaches
- ☐ Fractured jaw
- ☐ Anemia or blood disorders
- ☐ Hay Fever or sinus trouble
- ☐ Allergies or hives
- ☐ Asthma
- ☐ Autism
- ☐ ADHD / ADD
- ☐ Premature Birth
- ☐ Hearing Problems
- ☐ Intellectual Disability
- ☐ Congenital Birth Defects
- ☐ Speech Problems
- ☐ Behavioral Problems
- ☐ Pregnancy
- ☐ Radiation Treatment
- ☐ Autoimmune System Problems
- ☐ COVID-19; Date of positive test result _____
- ☐ Other:

For those conditions marked, please explain:

Does your child require an antibiotic before dental treatment? **Yes** **No**

If yes, please note antibiotic _____

Preferred Pharmacy _____

Address/Cross Streets _____ Phone _____

ALLERGIES

Is your child allergic to, or has your child reacted adversely to any of the following?

- ☐ Latex
- ☐ Penicillin or Other Antibiotics
- ☐ Local Anesthesia
- ☐ Codeine or Other Drugs
- ☐ Aspirin
- ☐ Other:

I certify that the information I have given is correct to the best of my knowledge. If any changes do occur, I will notify the office and update my file.

Signature _____ Date _____

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DENTAL APPOINTMENT POLICY

Scheduled appointments are specifically time managed based on appointment type. We reserve a time slot for the patient with one of our Providers to ensure patient receives the highest level of care. To guarantee maximum access to dental services for all our patients, we ask that you please respect your designated appointment(s) and acknowledge our Dental Appointment Policy.

In the event of running late to a scheduled appointment, please contact the office immediately, providing the office with an estimated time of arrival; this allows the office to adjust the schedule accordingly and update the dental staff. If patient arrives to scheduled appointment 15 minutes ***after*** their scheduled time, the office will reschedule the appointment.

In the event of needing to reschedule or cancel an appointment, please contact the office as soon as possible, but no later than 24 hours prior to patients scheduled appointment. Appointments are very high in demand and by giving us advance notice, this allows us to offer the time slot to another patient who is in need or requesting an appointment.

We ask all patients to honor their reserved time with our Providers. In doing so, we require the following:

Tips to Avoid a "No Show" Appointment

- Confirm your appointment
  - Always make sure we have the most up to date contact information.
- Arrive 5-10 minutes early.
- Give us 24-hour notice when needing to cancel/reschedule an appointment.
  - We understand that emergencies do happen. If you experience extenuating circumstances and must miss an appointment without giving us 24-hour notice, please ask to speak to a member of management. You may contact our office 24 hours a day, 7 days a week. If it is outside of business hours, please leave a message.

Definition of a "No-Show" Appointment

- Does not arrive to the appointment at all
- Cancellation of an appointment with less than 24-hour notice
- Arrives more than 15 minutes late and is consequently unable to be seen

Consequences of "No Show" Appointment (per 12-month period) & Same Day Policy

- 1st missed appointment: reminder about our "No Show" policy.
- 2nd missed appointment: policy reminder and warning. Can result in the office unable to reserve specific appointment times for the patient and the patient will be placed on the same day appointment policy.
- 3rd missed appointment: office will no longer reserve appointment time(s) for the patient. The patient will be placed on the same day appointment policy.
  - Same Day Appointment Policy: As the parent/guardian, you will need to call the office the day you would like the patient to be seen and ask our availability. If the office has available time slot(s), patient(s) will be scheduled. A maximum of two family members per day will be scheduled under the same day policy.
  - If the patient is placed on the same day policy, an appointment is scheduled, and patient does not show up, the patient/family will be dismissed from the practice.

I HAVE READ, UNDERSTAND, AND AGREE TO THE DENTAL APPOINTMENT POLICY NOTED ABOVE

Signature _____ Relationship to Patient _____ Date _____