Child Health/Dental History Form

ADA American Dental Association®
America's leading advocate for oral health

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ❑ F ❑	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ..... ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	1. ❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2. ❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3. ❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	5. ❑	❑
6.	Has the child ever been hospitalized?	6. ❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	7. ❑	❑
8.	Has the child ever received a general anesthetic?	8. ❑	❑
9.	Does the child have any inherited problems?	9. ❑	❑
10.	Does the child have any speech difficulties?	10. ❑	❑
11.	Has the child ever had a blood transfusion?	11. ❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	12. ❑	❑
13.	Does the child experience excessive bleeding when cut?	13. ❑	❑
14.	Is the child currently being treated for any illnesses?	14. ❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	15. ❑	❑
16.	Has the child had any problem with dental treatment in the past?	16. ❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	17. ❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	18. ❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	19. ❑	❑
20.	Has the child had any orthodontic treatment?	20. ❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	22. ❑	❑
23.	**Is fluoride toothpaste used?**	23. ❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24. ❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	25. ❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	27. ❑	❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist
Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____
Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Appointment Confirmation Policy

We get it—you never miss an appointment. Once you've scheduled, you're committed to it.

But life gets in the way and even the best laid plans are forgotten, including the important dental check up. This is why we use a patient reminder system providing a convenient and simple tool to help you remember your next dental visit.

How our patient reminder system works:

1. First Appointment Confirmation: Two weeks before your appointment, you will receive a text message or email asking you to confirm that you plan on attending your upcoming visit.
    - To confirm, you must respond to the prompt in either the text message or email.
    - By text, simply reply with the letter C
    - Via email, click on the Confirm button and your appointment is saved
    - On the day of your confirmed appointment, you will receive an appointment reminder
2. Second Appointment Confirmation: If you fail to respond to the first text message or email, you will receive a second appointment confirmation two to four days before the appointment.
    - To confirm, see steps above
    - If confirmed, you will receive a friendly reminder on the day of your appointment
3. **Unconfirmed appointments will be canceled**. If the appointment remains "unconfirmed" 24 hours prior to the scheduled time, it is canceled and removed from the schedule.

This policy allows us to treat as many patients as possible by replacing unconfirmed appointments with patients who are on a waiting list. Utilizing this system allows us to quickly replace a "schedule opening" with another patient eager to see the dentist.

We value each of our patients and believe this process benefits everyone. Your cooperation in this matter is greatly appreciated.

ACKNOWLEDGEMENT

My signature below indicates that I have read, understood and agree to the appointment confirmation policy above.

_____ _____

Email Cell phone

_____ _____

Printed Name of Patient Date

_____

Signature of Patient/Responsible Party

COVENTRY FAMILY DENTAL

Dmitry Gelfand, DDS
903 Tiogue Ave Coventry, Rhode Island 02816
(401) 821-5864 info@smilingri.com

Appointment Policy

Our goal is to provide quality dental care in a timely manner. In order to do so, we ask that patients adhere to our cancellation and no show policy. The policy enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT

In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. We ask that you contact our office two business days (48 hours) in advance to cancel or reschedule your appointment.

NO SHOW POLICY

A 'no show' is an appointment that was not canceled in advance (minimum of 24 hours in advance). No shows inconvenience other patients who need dental care. A 'no show' for a scheduled appointment will result in a fee of $50.

LATE ARRIVALS

In an effort to serve our patients in a timely manner, we ask that you are on time for your scheduled appointment. In the event you are running late, please call the office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule.

Thank you for choosing Coventry Family Dental for your dental needs. We look forward to a long lasting relationship with you.

ACKNOWLEDGEMENT

My signature below indicates that I have read, understand and agree to the appointment policy above.

_____ _____

Printed Name of Patient Date

_____

Signature of Patient/Responsible Party

Coventry Family Dental

903 Tiogue Avenue

Coventry, RI 02816

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

_____

_____

_____

How did you hear about us? Choose one:

- ☐ Social media
- ☐ Old Theater Diner Ad
- ☐ Sign in front of office
- ☐ Friend/Family (who can we thank):

  _____

- ☐ Other:_____

Don’t forget to leave us a GOOGLE review!
Thank you!!