

Child Health/Dental History Form

Patient's Name <small>LAST FIRST INITIAL</small>			Nickname	Date of Birth	
Parent's/Guardian's Name			Relationship to Patient		
Address <small>PO OR MAILING ADDRESS CITY STATE ZIP CODE</small>					
Phone <small>Home Work</small>			Sex M <input type="checkbox"/> F <input type="checkbox"/>		
Have you (the parent/guardian) or the patient had any of the following diseases or problems? <input type="checkbox"/> Yes <input type="checkbox"/> 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:					
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> HIV +/-AIDS	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Fainting	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Mumps	<input type="checkbox"/> Tobacco/Drug Use
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Kidney	<input type="checkbox"/> Pregnancy (teens)	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder	<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Hearing	<input type="checkbox"/> Latex allergy	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart	<input type="checkbox"/> Liver	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Bones/Joints	<input type="checkbox"/> Ear Aches	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Measles	<input type="checkbox"/> 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.	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	2.	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	3.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the child ever been hospitalized?	6.	<input type="checkbox"/>	<input type="checkbox"/>
7. Does the child have a history of any other illnesses? If yes, please list: _____	7.	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child ever received a general anesthetic?	8.	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the child have any inherited problems?	9.	<input type="checkbox"/>	<input type="checkbox"/>
10. Does the child have any speech difficulties?	10.	<input type="checkbox"/>	<input type="checkbox"/>
11. Has the child ever had a blood transfusion?	11.	<input type="checkbox"/>	<input type="checkbox"/>
12. Is the child physically, mentally, or emotionally impaired?	12.	<input type="checkbox"/>	<input type="checkbox"/>
13. Does the child experience excessive bleeding when cut?	13.	<input type="checkbox"/>	<input type="checkbox"/>
14. Is the child currently being treated for any illnesses?	14.	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
16. Has the child had any problem with dental treatment in the past?	16.	<input type="checkbox"/>	<input type="checkbox"/>
17. Has the child ever had dental radiographs (x-rays) exposed?	17.	<input type="checkbox"/>	<input type="checkbox"/>
18. Has the child ever suffered any injuries to the mouth, head or teeth?	18.	<input type="checkbox"/>	<input type="checkbox"/>
19. Has the child had any problems with the eruption or shedding of teeth?	19.	<input type="checkbox"/>	<input type="checkbox"/>
20. Has the child had any orthodontic treatment?	20.	<input type="checkbox"/>	<input type="checkbox"/>
21. What type of water does your child drink? <input type="checkbox"/> City water <input type="checkbox"/> Well water <input type="checkbox"/> Bottled water <input type="checkbox"/> Filtered water			
22. Does the child take fluoride supplements?	22.	<input type="checkbox"/>	<input type="checkbox"/>
23. Is fluoride toothpaste used?	23.	<input type="checkbox"/>	<input type="checkbox"/>
24. How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	24.	<input type="checkbox"/>	<input type="checkbox"/>
25. Does the child suck his/her thumb, fingers or pacifier?	25.	<input type="checkbox"/>	<input type="checkbox"/>
26. At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____			
27. Does child participate in active recreational activities?	27.	<input type="checkbox"/>	<input type="checkbox"/>

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 _____



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

We request that you notify us at least 24 hours in advance if you need to cancel or reschedule your appointment. Cancellations made with less than 24 hours' notice may be subject to a \$50.00 fee.

NO SHOW POLICY

A "no-show" occurs when a patient fails to arrive for their scheduled appointment without notifying the office. A no-show will result in a \$50.00 to \$75.00 fee per scheduled hour.

Two (2) or more missed appointments or late cancellations in a 12-month period may result in dismissal from our practice.

LATE ARRIVALS

We strive to start all appointments on time. If you arrive more than 7 minutes late for your appointment, we may need to reschedule your appointment to avoid delaying other patients. If time permits, we may be able to complete a portion of the scheduled work, or you may need to wait for an opening on the same day.

APPOINTMENT CONFIRMATIONS

To ensure our schedule runs smoothly, we require confirmation for all scheduled appointments.

As a courtesy, we send appointment reminders in advance via text, email, and phone call. We ask that you respond to the confirmation request within 24 hours of your scheduled appointment.

If an appointment remains unconfirmed 24 hours prior to the scheduled time, we reserve the right to cancel the appointment and offer the time slot to another patient.

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



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Notice of Privacy Practices — Summary

Effective Date: February 16, 2026

This summary explains how Coventry Family Dental may use and disclose your health information and describes your privacy rights. A full Notice of Privacy Practices is available upon request.

Our Legal Responsibilities

We are required by law to:

- Protect the privacy of your health information
- Provide you with this Notice
- Follow the privacy practices described here

How We May Use and Share Your Health Information

We may use and disclose your health information for the following purposes:

Treatment

To provide, coordinate, or manage your dental care, including sharing information with other healthcare providers involved in your care.

Payment

To bill and receive payment from insurance companies or other payers.

Health Care Operations

For practice operations such as quality improvement, staff training, licensing, and business management.

As Required or Permitted by Law

Including public health activities or to prevent a serious threat to health or safety.

Special Privacy Protections for Substance Use Disorder Records

(42 C.F.R. Part 2)

Some records related to substance use disorder diagnosis, treatment, or referral are protected by federal law and have stricter confidentiality requirements.

Coventry Family Dental may receive this information as part of your health history or through coordination of care.

These records may be used or disclosed:

- With your written consent, or
- Without your consent only when allowed by federal law, such as for medical emergencies or certain audits or court orders

Federal law generally prohibits re-disclosure of this information unless specifically permitted.

Certain Information Has Extra Protection

Some types of health information, including substance use disorder records, are subject to additional protections under federal or state law. We follow all applicable laws when handling this information.

Your Privacy Rights

You have the right to:

- See or get a copy of your health records
- Ask us to correct your records
- Request limits on how we use or share your information
- Request confidential communications
- Receive a list of certain disclosures
- Get a paper copy of this Notice at any time

Changes to This Notice

We may change this Notice, and any changes will apply to all health information we maintain. Updated Notices will be available in our office and on our website.

Questions or Complaints

If you have questions or believe your privacy rights have been violated, contact us or file a complaint with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Acknowledgment Of Receipt

Please sign and date to acknowledge that you received this Notice of Privacy Practices

Name: _____

Date: _____