PERSONAL HISTORY

(ALL INFORMATION WILL BE HELD IN STRICT CONFIDENCE)

Date _____

Patient's Last Name _____ First _____ MI _____ M/F _____

Home Addresss _____ City _____ State _____ Zip _____

Home Phone _____ Date of Birth _____ Age _____

Father's Name _____ Social Security Number _____ DOB _____

Home Address _____ City/State _____ Zip _____ Phone _____

Father Employed By _____ Occupation _____ Bus. Phone _____

Mother's Name _____ Social Security Number _____ DOB _____

Home Address _____ City/State _____ Zip _____ Phone _____

Mother Employed By _____ Occupation _____ Bus. Phone _____

Have we seen any other family members? _____

Who referred you to our office? _____

MEDICAL-DENTAL HISTORY

What is your main problem? _____

How long has it troubled you? _____

Are you under a physician's care now? _____

For what? _____

_____

What major operations have you had? _____

_____

What drugs or medicines are you taking now? _____

_____

What drugs, medicines or other things are you allergic to? _____

_____

When was your last complete physical exam? _____

When was your last complete dental exam? _____

Age _____ Height _____ Weight _____

	YES	NO	DO NOT KNOW
Have you had any past complicated extractions?			
Have you had radiation treatments?			
Have you had prolonged bleeding when cut?			
Do you have a heart pacer?			
Do you wear contact lenses?			
Women—are you pregnant?			
Is there a history of or problem with:			
Diabetes			
Heart disease			
Lung disease			
Kidney disease			
Liver disease			
AIDS			

	YES	NO	DO NOT KNOW
Recent weight change			
High blood pressure			
Low blood pressure			
Blood diseases			
Shortness of breath			
Chest pain			
Epilepsy			
Tuberculosis			
Anemia			
Rheumatic fever			
Hepatitis			
Swelling of feet or ankles			
Asthma			
Fainting or dizziness			
Excessive thirst			
Frequent cough			
Pain in region of the ear			
Other . . . What? _____			

Summary (Dr. use)

✓

Signature of Patient (Parent or Guardian if Patient is minor)

_____ Date _____

(over)

DOCTOR'S NOTES

HIPAA
(Health Insurance Portability Accountability Act)
Notice of Privacy Practices

1. **To Provide Treatment —** We will use your health information you provide within our office to give the best dental care as possible. This may include sharing your information with referring dentists, physicians, pharmacies, clinical and dental laboratories or other health care personnel rendering treatment.

2. **To Obtain Payment —** A written invoice stating dental treatment performed will be sent to your insurance company and provided to you as well. This will include all services rendered in order to collect payment.

3. **Abuse or Neglect —** Government authorities will be notified if we believe a patient is the victim of abuse, domestic violence or neglect. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically or authorized by law or with the patient's agreement.

4. **Friends, Family or Caregiver's —** We will share your information with only those friends, family, or caregiver's when informed by you, the patient. This includes medications, treatment needed/performed and payment history. Written permission will be needed before disclosing any information.

5. **Communication and Appointments —** It has always been our courtesy to remind patients of upcoming appointments. This has included post cards/confirmation calls. By marking the appropriate line, you will let us know if you wish to continue to receive reminders or not.

   _____ Yes, I do wish to continue to receive postcard/confirmation calls

   _____ No, I would prefer not to receive postcards/confirmation calls

Thank you for taking the time to review the latest HIPAA regulations. Please sign the bottom of this form so we may keep it part of your record. If you would like a copy of this, please let us know.

_____ _____

Signature Date

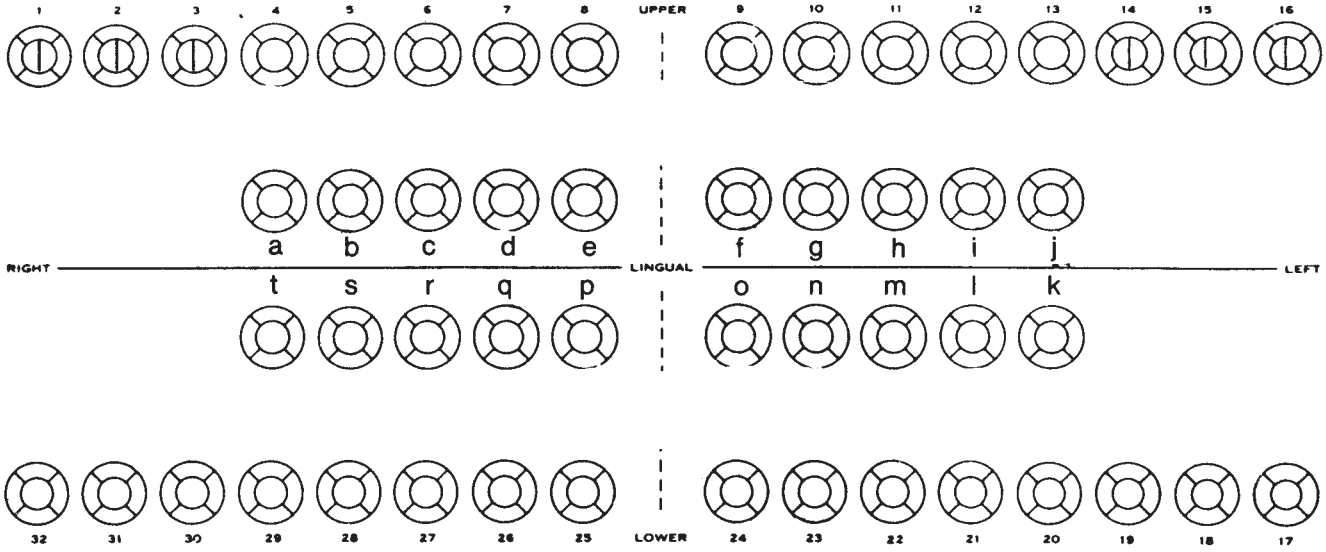
Person responsible for this professional fee _____
Mailing Address _____

How do you plan to pay for the professional fees?
Cash _____ Check _____
Other, please explain _____
If check, driver's license no. of person writing check _____

DENTAL INSURANCE COVERAGE INFORMATION:

1. Name of insured _____ Social Security # _____
Name of Insurance Co. _____
Address _____
Policy# _____ Group# _____

2. Other Dental Coverage? Yes _____ No _____
Name of Insured _____ Social Security # _____
Name of Insurance Co. _____
Address _____
Policy # _____ Group # _____



CS_____ **GI**_____

Occlusion
Permanent I_____ II_____ III_____
Primary MS_____ DS_____ FTP_____
Overjet_____mm Overbite_____mm
_____

Extra Oral _____
Mucosa _____
Tongue _____
Frenum _____
Gingiva _____
Floor of mouth _____
Palate _____
Lips _____

No. of teeth _____
Traumatic injuries _____
Condition of present dentistry: NA _____
Overhangs _____
Margins _____
Space management _____
Other _____
_____

NOTES

INFORMED CONSENT

The necessary treatment has been explained to me. I* hereby give J. Michael Lloyd, D.D.S. and/or associates or assistants of choice, my consent to the performing of the treatment and whatever procedures may be deemed necessary or advisable in addition to the planned procedure. I understand the hazards in connection with these procedures such as swelling, bruising, infection, tingling or numbness of the lips, tongue, gums and/or face and post operative discomfort. I understand and I am not to operate any vehicle or hazardous devices or drink alcoholic beverages for at least 6 (six) hours or until fully recovered from the anesthetic and/or medication. I agree to the use of a local or general anesthetic, sedation and analgesia depending on the judgment of the dentists involved in my case. I have been informed of possible complications of the surgery, anesthesia, other drugs and medications. The fee for these services has been explained to me and is satisfactory.
*In case the patient is a minor "I" refers to parent or guardian.

Telephone Consent _____ Date _____

✓ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN

Witness Signature _____

Kidzania Pediatric Dentistry
Dentistry for Children and Teenagers
3851 SW Green Oaks Blvd #123
Arlington, TX. 76017
817-483-2445

Office Policies

Accompanying your child

We ask that you allow your child to accompany our staff through the dental experience. Children aged 3 and up will go back to see the Dentist by themselves with our trained staff. Children aged 2 and under will be allowed to come back with a parent or legal guardian. We ask that the parents or the legal guardian accompany their child(ren) to the appointment.

Finances

Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan, which fits your schedule and budget. We accept cash, Mastercard, Visa and Discover.

Appointment Scheduling

Our office will attempt to schedule appointments at your convenience and when time is available. Preschool children (1-6 years) should be seen in the morning because that is when they are fresher and we can work more slowly with the child for their comfort. Dental appointments are an excused absence and we will provide your child with a school note. Missing school can be kept to a minimum when regular dental care is in place.

By reading and signing this form you agree to adhere to these office policies. If you have any questions or concerns regarding the treatment of your child, our office procedures, finance or anything else, please feel free to ask.

_____ _____
Parents Signature Date

HIPAA (Health Insurance Portability Accountability Act)

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_____ _____
SIGNATURE OF PATIENT, PARENT OR GUARDIAN Date