Alka V. Cohen, D.D.S., M.S., P.C.
Diplomate American Board of Pediatric Dentistry
Pediatric Dentistry

DENTISTRY FOR CHILDREN AND TEENAGERS
8142 Country Village Drive • Suite 101 • Cordova, TN 38016 • (901) 756-4447 • (901) 756-4441 • Fax (901) 756-8784

CONSENT AND AUTHORIZATION TO RELEASE DENTAL RECORDS OR INFORMATION CONCERNING DENTAL RECORDS

I, _____, authorize Alka V. Cohen, D.D.S., M.S., P.C.,
NAME OF PARENT OR LEGAL GUARDIAN
Pediatric Dentistry to copy and release any and/or all of my child's dental records or information concerning my child's dental records including findings, treatment rendered and opinions as to my child's dental or medical condition, for the purpose of processing claims, or provide the same to any representative or agency authorized to inspect such records for auditing or monitoring purpose or treatment.

This release shall remain in effect until it is withdrawn by me in writing, and the written notice being addressed to Alka V. Cohen, D.D.S., M.S., P.C., Pediatric Dentistry at the above address.

I understand that I may revoke this consent to release information at any time, in writing and that pursuant to confidential and privileged communication laws, no disclosure will be made without my proper authorization.

_____ _____

Signature of Parent/Legal Guardian with authority to act for minor **Date**

I. GENERAL INFORMATION

Child's Name _____ Nickname _____ Sex _____ Race _____
Date of Birth _____ Place of Birth _____ SS# _____
Child's Physician _____ Phone# _____ Family Dentist _____
Father's Name _____ Birth Date _____ SS# _____
His Address _____ State; Zip _____ Phone # _____
Present Employer _____
Employer's Address _____ City; State _____ Zip _____
Present Position _____ How Long _____ Phone # _____
Father's Dental Insurance _____ Group # _____ Phone # _____
Address _____ City; State _____ Zip _____
Mother's Name _____ Birth Date _____ SS# _____
Her Address _____ State; Zip _____ Phone # _____
Present Employer _____
Employer's Address _____ City; State _____ Zip _____
Present Position _____ How Long _____ Phone # _____
Mother's Dental Insurance _____ Group # _____ Phone # _____
Address _____ City; State _____ Zip _____
Additional Dental Insurance _____ Group # _____
Who does the child live with? _____
Names & ages of brothers & sisters _____
Who referred you to us, so we may thank them? _____
If you want your appointment confirmed please give us a number where you can be reached during the day _____

ARE YOU THE PARENT OR LEGAL GUARDIAN OF THIS CHILD? YES / NO
IF NO ------- STOP & SEE THE OFFICE MANAGER

II. CHILD'S HEALTH HISTORY

Is your child in good health? ____ yes _____ no. Date of child's last medical exam _____
Is your child up to date with immunizations? _____ yes _____ no.

Check any of the following that may pertain to your child.

_____ Heart Condition/Murmur	_____ Rheumatic Fever	_____ Mental Disorder
_____ Liver Disorder	_____ Asthma	_____ Nervous Disorder
_____ Kidney Disorder	_____ Sickle Cell Anemia/Trait	_____ Bleeding Disorder
_____ Lung Problems	_____ Diabetes	_____ Speech Disorder
_____ Brain Damage	_____ Downs Syndrome	_____ Hearing Disorder
_____ Epilepsy	_____ Cerebral Palsy	_____ Vision Disorder
_____ Tuberculosis	_____ Autism	_____ Allergies
_____ Hepatitis	_____ Emotional Disorder	_____ Blood Transfusion
_____ High Blood Pressure	_____ Tumor/Malignancy	_____ AIDS/ARC/HIV positive
		_____ Other

Is your child presently taking any medications? _____yes _____no; If yes, please list _____
Is your child presently being treated by a physician? _____yes _____no
Has your child ever been in the hospital or had general anesthesia? _____yes _____no
Is your child allergic to ANY medications? _____yes _____no If yes, please list _____
Has your child had ill-effects from local anesthetics? _____yes _____no

Our office will assist you in completing insurance claim forms, although the responsibility for the entire professional fee remains with YOU. Payment is required at the time services are rendered. Parent of Guardian who authorizes treatment in our office assumes responsibility for payment of fees. If any default occurs in payment, the undersigned agrees to pay all costs of collection plus reasonable attorneys' fees and court costs in the event the account is placed with an attorney for collection.

Parent or Guardian's Consent: I agree to the treatment and care deemed necessary by the office staff for the safety and well-being of my child.

_____ _____ _____
Signature *Relationship to Child* *Date*

HEALTH Hx UPDATE _____ _____ _____ _____ _____

III. CHILD'S DENTAL HISTORY

Child's Name _____ D.O.B. _____ Parent/Guardian's Name _____ Date _____

Explain briefly why you brought your child for dental care. _____

_____

Does your child know the purpose of the visit? _____

Is this your child's first dental visit? _____ yes _____ no date of last visit _____

Did you remain with your child during previous dental procedure? _____

How does your child feel about visiting the dentist? _____

How does your child feel about visiting the physician? _____

What is your child's response under stress? _____

Has your child had any difficulty accepting dental treatment previously? _____

Do you anticipate your child having difficulty accepting dental treatment? _____

Has your child ever received special medicine before receiving dental care? _____

Does your child have a tooth that hurts now? _____ yes _____ no

If yes, please explain _____

Has your child had any injuries to teeth, gums, lips? _____

Were there any unusual problems with your child getting his/her teeth? _____ yes _____ no

If yes, please explain _____

Has it ever been necessary for a dentist to remove any of your child's baby teeth? _____ yes _____ no

If yes, please explain _____

Are there any abnormal dental conditions or unusual dental problems found in other children or adults in your family or in other blood relatives, e.g. missing, extra or impacted teeth, tumors, cyst of jaw, deformed or discolored teeth. _____ yes _____ no

If yes, please explain _____

What was the way of providing nourishment for your child during the first year? _____

At what age was he/she weaning to cup? _____

Does you child drink fluoridated water? _____

Do you give your child fluoride supplement? _____

Does he/she use fluoride toothpaste? _____

Do you consider your child to be _____ advanced in learning process _____ progressing normally _____ a slow learner.

Does your child interact well with other children his/her age? _____

Does your child have any habits?

_____ mouth breathing _____ thumb or finger sucking _____ snoring

_____ teeth clenching _____ pacifier/object sucking _____ teeth grinding

_____ lip sucking _____ others _____

Does your child have any disability that we should be aware of in order to make dental treatment more acceptable?

If yes, please explain _____

Is there any other information regarding your child's medical or dental history that may affect his/her dental treatment? _____

_____

_____

_____ _____ _____

Signature *Relationship to Child* *Date*

DENTAL HEALTH Hx UPDATE _____ _____ _____ _____ _____