Karen Nation, D.M.D.
Child Patient Information

Date: _____ Height_____ Weight_____

Patient Name:_____ Preferred Name:_____
Last First MI

□ Male □ Female Parent's name _____

Child's Birth Date:_____ Social Security#_____

Phone (Home):_____ Pager/Cell (Parent):_____

Home Address: _____
Street

_____
City State Zip Code

Whom may we thank for referring you to our office?_____

Has child ever had any of the following? Please <u>circle</u> those that apply, and <u>list any medicine</u> child is taking for each condition.

HIV/AIDS
Anemia
Asthma
Blood Pressure Problem
Diabetes (Type 1 or Type 2)
Epilepsy
Heart Disease
Heart Murmur
Artificial Heart Valve
Hepatitis
Joint Replacement
Pacemaker
Radiation Treatment
Rheumatic Fever
Tuberculosis
Transplant/Prosthesis
Other medical problems/other medicines

- Does child have any health problems that need further clarification? □ Yes □ No
  If yes, please explain:_____
- Name of Primary Physician and location: _____
- Preferred Pharmacy and location:_____

Dental

- **Date of Last Dental Visit: _____**
- Why did child leave previous dentist?_____
- Has child had any **complications or allergic reactions** after previous dental treatment? □ Yes □ No If yes, please explain:_____

_____

- Does child prefer **Nitrous Oxide** (laughing gas) during treatment? □ Yes □ No
- If child could change his or her smile, what would you do?_____
- Is child having tooth pain (please describe)? _____

_____

- Please list any problems or concerns you may have with your child's teeth.

_____

_____

- Does your child ever snore at night? _____
- Does your child grind his or her teeth? _____

Other

Child's School _____

To the best of my knowledge, all of the information provided is true and correct. If there is a change in my child's health history, I will inform the doctor at the next appointment.

X_____Date:_____

Signature of patient, parent or guardian

Karen Nation, D.M.D.
13819 English Villa Drive
Louisville, KY 40245
Phone: (502) 244-6886

CONSENT FOR TREATMENT AND OFFICE POLICIES

I willingly consent to the treatment on _____ (name of patient) for all dental procedures deemed necessary for dental diagnosis. I understand that radiographs and certain other procedures are necessary to make a diagnosis. I will be informed of any condition found on examination and any needs that are necessary for comprehensive treatment.

I give consent for all treatments, medications and operations upon the teeth that may be necessary to correct oral deficiency, abnormality and/or infection. I consent to the administration of anesthetic agents for my dental treatment. I understand that as with any dental treatment, there are possible risks involved with my treatment, and that no guarantee is made to the results that may be obtained.

I authorize Dr. Karen Nation to release any information and records concerning my treatment as may be necessary to process insurance claims or payment for the care and treatment provided. I also understand that if for any reason insurance fails to pay for treatment, I am responsible for payment. I also authorize Karen Nation Dentistry to obtain any medical records deemed necessary from my medical doctor or dentist. I agree to have any photos taken of me to be used for education and training.

Dr. Nation takes great pride in scheduling patients for optimum treatment, which means reserving time for each patient individually based on their needs. **I am aware that the cancellation of an appointment without 24-hour notice will result in a $55 fee**.

I have received HIPAA Policy information for Dr. Karen Nation Dentistry. I certify that I have read and fully understand the above consent.

_____ _____

Signature of Patient or Legal Guardian Date