Karen Nation, D.M.D. Dentistry
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): ____________________ Cell (Parent): ____________________________

Can we send appointment reminders via text? ☐ Yes ☐ No

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 circle those that apply.

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

List any medications child is currently taking: _____________________________________
____

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: ____

Dentall

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? Yes No

Does your child grind his or her teeth? Yes No

<u>Other</u>

Child's School/Grade Level ____

To the best of my knowledge, all 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.

____ Date: __________________
Signature of 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 conditions found upon 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 payments 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 D.M.D. 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 cancellation of appointment without 24-hour notice will result in a $55 fee**.

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

_________________________________ _________________________________
Signature of Patient or Legal Guardian Date