WAIMĀNALO HEALTH CENTER

Patient Registration: MINOR

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Legal Sex (Please check one)*
☐ Male ☐ Female

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.

Gender Identity
☐ Male
☐ Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Other
☐ Chose not to disclose

Sexual Orientation
☐ Lesbian, gay or homosexual
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't know
☐ Chose not to disclose

Home Address	City	State	Zip Code
Mailing Address	**City**	**State**	**Zip Code**

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone	☐ Cell Phone	☐ Day Phone	☐ Email Address
( )	( )	( )	

Housing Status: ☐ Not Homeless ☐ Homeless: ☐ Doubling Up ☐ Shelter ☐ Street, Beach, Etc. ☐ Transitional ☐ Unreported

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Race (pick one below that best describes you):

☐ African American/Black ☐ White ☐ Chinese ☐ Chuukese ☐ Filipino ☐ Guamanian
☐ Japanese ☐ Korean ☐ Laotian ☐ Marshallese ☐ Micronesian ☐ Native American
☐ Native Hawaiian ☐ Portuguese ☐ Puerto Rican ☐ Samoan ☐ Tongan ☐ Vietnamese
☐ Other Asian ☐ Other Pacific Islander ☐ All Other (please specify): _____

Patient Portal *is WHC's latest technology that allows you to schedule and view appointments, request medication refills and see lab results, communicate with your health care team, ask questions about your bill and request your health record.*

Are you enrolled into Patient Portal? ☐ Yes ☐ No **If No, do you need assistance to enroll?** ☐ Yes ☐ No

PARENT OR LEGAL GUARDIAN INFORMATION

Relationship of Guarantor to Patient (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Other: _____

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Home Address	City	State	Zip Code
Mailing Address	**City**	**State**	**Zip Code**

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone	☐ Cell Phone	☐ Day Phone	☐ Email Address
( )	( )	( )	

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Separated ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Employer/School Name: ☐ Employed ☐ Unemployed ☐ Student ☐ Full-Time ☐ Part-Time ☐ Casual ☐ Retired

Occupation:

Family Size (includes self, spouse, & children under 18): _____

Family Income: $ _____ ☐ Monthly ☐ Annual

Patient Registration: MINOR

Patient Name: _____ MRN: _____

Parent/Guardian Name: _____ PERSON NO: _____

EMERGENCY CONTACT INFORMATION CONTINUED		
Emergency Contact Name:		**Relationship:**
Home Phone	**Work Phone**	**Cell Phone**
Emergency Contact Name:		**Relationship:**
Home Phone	**Work Phone**	**Cell Phone**

_____ Initials I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby authorize WHC to release information to my insurance carrier or organization in order to process claims on my behalf. I authorize payment of medical benefits to WHC for services rendered.

_____ Initials I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initials I consent and authorize Waimanalo Health Center to provide medical services including but not limited to immunizations and screenings for my son/daughter/ward.

_____ Initials I received the Privacy Practice Notice.

_____ _____

Signature of Parent/Legal Guardian Date Signed Signature of Responsible Party Date Signed

FOR OFFICE USE ONLY		
MEDICAL SERVICES – Record #_____		
Pt Status Type: ☐ Inactive ☐ Scheduled ☐ Non-WHC Active ☐ Active ☐ Dental Patient Only	**Valid ID:** ☐ Scan ID ☐ Update NG Pt Picture	**Insurance:** ☐ Scan Card ☐ Update Info/Card
Collected By: _____ Date: _____	Entered By: _____ Date: _____	
DENTAL SERVICES – Person #_____		
Pt Status Type: ☐ Inactive ☐ Scheduled ☐ Non-WHC Active ☐ Active ☐ Dental Patient Only	**Valid ID:** ☐ Scan ID ☐ Update NG Pt Picture	**Insurance:** ☐ Scan Card ☐ Update Info/Card
Collected By: _____ Date: _____	Entered By: _____ Date: _____	

Patient Registration: INSURANCE

Patient Name: _____ MRN: _____

PRIMARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

SECONDARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

PRIMARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

SECONDARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Parent ☐ Child ☐ Spouse ☐ Step-Child ☐ Other: _____

Policy Holder Name	**Date of Birth**	☐ **Male** ☐ **Female** ☐ **Unknown**

Plan Name	**Policy # / Subscriber #**	**Group #**	**Effective Date:**	**Expiration Date:**

Home Address	**City**	**State**	**Zip Code**

Home Phone	**Work Phone**	**Cell Phone**

WAIMĀNALO HEALTH CENTER

CONSENT FOR CARE: MINOR

I,_____, the undersigned, hereby give Waimānalo Health Center to examine my (son/daughter/ward):

Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth

to make such tests as are necessary for his/her diagnosis and care, and to give such treatment as the Waimānalo Health Center physicians deem necessary. This includes diagnosis and care at the Center clinic, at laboratories, X-ray facilities, clinics, emergency rooms and offices of specialists, and psychological tests.

I understand that for major surgery or other major procedures, special explanations will be made to me and special permission will be requested for me, unless the emergency is too great to wait to contact me.

This consent which I am signing is for the ongoing health care of my (son/daughter/ward) until I withdraw him/hear from the Center. I understand that it includes consent for general tests, tuberculin tests, applications to skin or mucous membranes, examination of mouth, genitals, rectum, and ears, repair of small cuts, and all other ordinary medical office procedures.

I am not hereby consenting to any experimental procedures nor to tests for research or scientific study.

My photograph and that of my child may be used for medical records and for publicizing the Waimānalo Health Center.

I certify that I have read (or had read to me) and fully understand the above consent for care. Any inapplicable statements were stricken or any exceptions to the above are indicated below before I signed. Exceptions:

_____

_____

_____

_____ _____

Parent/Legal Guardian Signature Date

WAIMĀNALO HEALTH CENTER

PARENT AUTHORIZATION & CONSENT FORM

I, _____, the _____
(Parent or Legal Guardian) (Relationship)

of _____ _____ and
(Minor's Full Legal Name) (Birthdate)

of _____ _____ and
(Minor's Full Legal Name) (Birthdate)

of _____ _____ and
(Minor's Full Legal Name) (Birthdate)

of _____ _____ and
(Minor's Full Legal Name) (Birthdate)

of _____ _____ and
(Minor's Full Legal Name) (Birthdate)

of _____ _____
(Minor's Full Legal Name) (Birthdate)

Authorize and consent to any examinations, x-rays, anesthetic, medical diagnosis, immunization, or treatment rendered by the Waimānalo Health Center in the event that my child(ren) are brought to the Center by the following persons:

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Signature of Parent or Legal Guardian) (Date)

Telephone number where Parents/Legal Guardians can be reached:

Father's Name	Business Phone	Home Phone
Mother's Name	Business Phone	Home Phone
Legal Guardian's Name	Business Phone	Home Phone

WAIMĀNALO HEALTH CENTER

PATIENT RIGHTS AND RESPONSIBILITIES

WAIMĀNALO HEALTH CENTER (WHC) ENCOURAGES PATIENTS AND THEIR `OHANA TO KNOW & EXERCISE THEIR RIGHTS AND RESPONSIBILITIES

As a Waimānalo Health Center Patient, you have the right to:	*As a Waimānalo Health Center Patient, your responsibilities are to:*
❖ Be treated with courtesy, dignity and respect—regardless of race, color, sex, age national origin, or beliefs. ❖ Be seen in a safe, secure environment and in a timely manner. ❖ Know the name of your health provider, and the names and positions of staff you encounter. ❖ Be informed of your condition and understand the treatments. ❖ Refuse treatment at any time and to be informed of the risks of the refusal of treatment. ❖ Be informed of the reasons for tests and treatments and to receive the results in a timely manner. ❖ Refuse to sign consent forms until you understand what you are signing. ❖ Refuse to participate in educational or experimental activities by choice. ❖ Participate in all decisions regarding your care as stated within the law. ❖ Identify a person whom you would like to make decisions for you when you are unable to do so, using the Advance Care Directives. ❖ Be referred for emergency or specialized services not provided by WHC. ❖ Have your health information protected and held in confidentiality. ❖ Obtain explanations of monies that you owe to the health center on your bill. ❖ Request and receive copies of your medical records at a small fee.	❖ Treat all persons in the health center with courtesy, dignity and respect at all times. ❖ Provide accurate information for registration, billing, payment, informed consents and changes that occur, including any changes in your address, phone number, insurance, and or any other contact information ❖ Provide information regarding your concerns to a patient advocate or may request to speak with the Dental Director, Chief Performance and Compliance Officer, Chief Medical Director or Chief Executive Officer. ❖ Be on time for scheduled appointments and to cancel appointments before the scheduled appointment, according to Waimānalo Health Center policies. This includes any specialty or referral appointments made for you. ❖ Provide requested information for your medical history accurately including past illnesses, medications, allergies, hospitalizations, family and social histories. ❖ Ask questions if you are unclear about papers and information that you and your provider have agreed upon. ❖ Keep your personal belongings in a safe place. Lost and/or stolen personal items are not the responsibility of Waimānalo Health Center.

Waimānalo Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you need language assistance, services free of charge, are available to you. Call 808-259-7949.

WE WISH TO OFFER YOU THE BEST HEALTH CARE POSSIBLE AND APPRECIATE YOUR INPUT AS A HIGHLY VALUED TEAM PLAYER.

I have reviewed and received a copy of the above Patient Rights & Responsibilities. I understand that if I or any of my family members do not follow the rules, I may not be able to receive care at this health center.

_____ _____

Print Name of Patient Date

_____

Patient or Legal Guardian Signature

WAIMĀNALO HEALTH CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Privacy Responsibilities:
Waimānalo Health Center (WHC) is required by law to maintain the privacy of your health information; provide this notice that describes the ways we may use and share your health information; and follow the terms of the notice currently in effect.

Privacy Promise: WHC understands that your health information is personal and protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. You have the right to be notified if a breach of protected health information occurs.

Uses and Disclosures of Health Information Permitted by Law: The following categories describe the ways that the WHC may use and disclose your health information. Some health records including confidential communications with a mental health professional, some substance abuse treatment records, some genetic results, and some health information of minors, may have additional restrictions for use and disclosure under state and federal laws. Your health information will be used or disclosed only for the following purposes:

When you receive care from WHC, we may use your health information for treating you, billing services, and conducting our normal business known as health care operations. Examples of how we use your information include:

Treatment: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment. We may call you by name in the waiting room when the provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Payment: We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or another third party. We may contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. We may disclose protected health information to other health care providers or third parties to assist in billing and collection efforts. You have the right to restrict disclosure of your protected health information to a health plan when you pay out of pocket in full for health care services.

Health Care Operations: We use health information to improve the quality of care, train staff and students, provide customer service, manage costs, conduct required business duties, and make plans to better serve our communities. For example, we may use your health information to evaluate the quality of treatment and services provided by our physicians, nurses, and other health care workers.

Individuals Involved in your Care or Payment of your Care: We may disclose your health information to a spouse, family member, close personal friend, or any individual identified by you if we obtain your agreement. You will have the opportunity to identify this person or to object to our disclosing information to them.

Business Associates: WHC may use or disclose health information about you with people who contract with us to provide goods and services used in your treatment or for hospital operations. Examples include copy services, consultants, interpreters, and health transcriptionists. The WHC requires these contractors to protect the confidentiality of your health information as we do.

Research: Under certain circumstances, we may use and disclose your health information for research purposes. Research projects are subject to a special review process that evaluates uses of health information; trying to balance the research needs with the need for patient privacy. Before we use or disclose health information for research, the project will have to be approved through this review process.

Fundraising: We may contact you to provide information about WHC sponsored activities, including fundraising programs and events. We would only use contact information, such as phone number and the dates you received treatment or services at WHC. Please inform us if you do not want us to contact you for these fundraising efforts.

Health Care Communications: To identify health-related services and products that may benefit you and then contact you about the services and products.

Deceased Individuals: We may release medical information to a coroner, medical examiner, or funeral director as necessary for them to carry out their responsibilities.

Organ Procurement Organizations: We may release your health information to organizations that handle organ procurement or organ, eye, or tissue transplants or to an organ donation bank, as required and necessary to facilitate organ or tissue donation and transplants.

Public Health Activities: WHC may use or disclose your health information with public health authorities in charge of preventing or controlling disease, injury, or disability. For example, the WHC is required to report infectious diseases to the Hawaii Department of Health; billing practices may be audited by the Hawaii State Auditor; records are subject to review by the Secretary of Health and Human Services; and the Federal Food and Drug Administration (FDA) to ensure product safety.

Workers Compensation: WHC may use or disclose health information about you for workers compensation or similar programs that provide benefits for work-related injuries or illnesses.

Judicial and Administrative Proceedings: In the course of a judicial or administrative proceeding in response to a legal order or other lawful purpose.

Threat to Health and Safety: We may use and disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of others.

Law Enforcement Officials: Specialized Government Functions: We may disclose information to the police or other law enforcement officials as required by law or in compliance with a court order. We may disclose information to military or veterans' authorities about Armed Forces personnel, under certain circumstances. We may also disclose information to authorized federal officials for purposes of lawful intelligence, counter-intelligence, and other national security activities.

All other users and disclosures, not described in this notice, require signed authorization. You may revoke your authorization at any time with a written statement submitted to Health Information.

Specially Protected Health Information: Unless otherwise required or permitted under law, disclosure of the following protected health information, outside our health center, requires your specific consent:

- AIDS/HIV information
- Mental health and mental illness records including psychotherapy notes
- Drug addiction and alcoholism (substance abuse) treatment records

Your individual Rights: You have the following rights concerning your health information. A request to exercise any of these rights must be made in writing to the Chief Performance and Compliance Officer and/or the Compliance Specialist.

Right to Alternative Communications: You have the right to request that WHC communicate with you in a certain manner. For example, you may ask that WHC contact you only at work, or a different address than your home address. You may request this during registration.

Right to Inspect and or Copy: You have the right to inspect and obtain copies of your health information. Usually, this includes health and billing records. *It does not include psychotherapy notes, or information we put together to prepare for legal action, and certain laws relating to laboratories.*
To obtain a copy of your health information, please submit a request in writing to the Medical Records Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services from your request.

We may deny your request to inspect and copy your records in certain very limited circumstances. We will notify you in writing if your request has been denied and explain how you may appeal the decision. In certain limited situations, we will have to deny you access and you will not have the right to appeal that decision.

Right to Amend: If you think that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. You must provide a reason for the amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create.
- Is not part of the health information kept by our facility.
- Is not part of the information that you are allowed to inspect.
- Is accurate and complete.

Right to Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made. This accounting will not include disclosures:

- For treatment, payment, or health care options
- To persons involved in your care or for notification purposes
- Incidental to an otherwise permitted use or disclosure
- To correctional institutions or other law enforcement officials
- As part of a limited data set
- For national security or intelligence purposes
- For any use or disclosure that you specifically authorized or requested

You request must state a time period, which may not be longer than 6 years and not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures within 30 days of your request, or notify you if we are unable to have the list within 30 days and by what date we can have the list; but this date will not exceed 60 days from the date you made the request.

Right to Request Special Restrictions: You have the right to request special restrictions on sharing of your health information. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care. We are not required to agree to your request for restrictions if we are unable to comply or believe it will negatively affect the care we provide for you. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, disclosure of specific information to your spouse.

Right to Copy of This Notice: You have the right to obtain a paper copy of this Notice at any time. Copies of your current Notice are available from our front desk staff.

Changes to this Notice: We reserve the right to change our privacy practices as described in this Notice at any time. Except when required by law, we will write and make available upon request a new Notice before we make any changes in our privacy practices. The privacy practices in the most current Notice will apply to information we already have about you as well as any information we receive in the future. The Notice will contain an effective date.

Contact Us: If you would like further information about your privacy rights, are concerned that your privacy rights have been violate, or disagree with a decision that we made about access to your health information, contact the Chief Performance and Compliance Officer at (808) 954-7156 and Compliance Specialist at (808) 954-7166.

All complaints must be submitted in writing. We will investigate all complaints and will not retaliate against you for filing a complaint with the Office of Civil Rights of the U. S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Waimānalo Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you need language assistance, services free of charge, are available to you. Call 808-259-7949.

I, _____, have read and/or received a copy of the Waimanalo Health Center's Notice of Privacy Practices.

Patient or Legal Guardian Signature	Print Name (if not the Patient Signature)	Date

Child Health/Dental History Form

ADA American Dental Association®
America's leading advocate for oral health

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)	Sex M ☐ F ☐	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ☐ Yes ☐ 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:

☐ Anemia	☐ Cancer	☐ Epilepsy	☐ HIV +/AIDS	☐ Mononucleosis	☐ Thyroid
☐ Arthritis	☐ Cerebral Palsy	☐ Fainting	☐ Immunizations	☐ Mumps	☐ Tobacco/Drug Use
☐ Asthma	☐ Chicken Pox	☐ Growth Problems	☐ Kidney	☐ Pregnancy (teens)	☐ Tuberculosis
☐ Bladder	☐ Chronic Sinusitis	☐ Hearing	☐ Latex allergy	☐ Rheumatic fever	☐ Venereal Disease
☐ Bleeding disorders	☐ Diabetes	☐ Heart	☐ Liver	☐ Seizures	☐ Other_____
☐ Bones/Joints	☐ Ear Aches	☐ Hepatitis	☐ Measles	☐ 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: _____	☐	☐
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	☐	☐
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	☐	☐
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	☐	☐
6.	Has the child ever been hospitalized?	☐	☐
7.	Does the child have a history of any other illnesses? If yes, please list: _____	☐	☐
8.	Has the child ever received a general anesthetic?	☐	☐
9.	Does the child have any inherited problems?	☐	☐
10.	Does the child have any speech difficulties?	☐	☐
11.	Has the child ever had a blood transfusion?	☐	☐
12.	Is the child physically, mentally, or emotionally impaired?	☐	☐
13.	Does the child experience excessive bleeding when cut?	☐	☐
14.	Is the child currently being treated for any illnesses?	☐	☐
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: _____	☐	☐
16.	Has the child had any problem with dental treatment in the past?	☐	☐
17.	Has the child ever had dental radiographs (x-rays) exposed?	☐	☐
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	☐	☐
19.	Has the child had any problems with the eruption or shedding of teeth?	☐	☐
20.	Has the child had any orthodontic treatment?	☐	☐
21.	**What type of water does your child drink?** ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water		
22.	**Does the child take fluoride supplements?**	☐	☐
23.	**Is fluoride toothpaste used?**	☐	☐
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	☐	☐
25.	Does the child suck his/her thumb, fingers or pacifier?	☐	☐
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	☐	☐

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 _____
Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org