Child Health/Dental History Form

ADA
American Dental Association
www.ada.org

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 _____

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Form S707

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or go online at www.adacatalog.org

THE GREATER NASHUA
DENTAL CONNECTION

CLINIC POLICIES

Please read each of the following policies and return this to the Office; if requested, a copy may be given to you. We ask that you adhere to these policies for your own safety as well as the safety of other patients and the clinic staff.

1. If a patient has a New Hampshire Medicaid card, please have it available at every visit.

2. Children will not be allowed in the waiting area unattended.

3. Only the patient will be allowed in the Treatment Area, unless a parent/guardian is requested by the Doctor or Hygienist.

4. **PAYMENT** is expected on the day of service.

BROKEN APPOINTMENTS

Unfortunately due to the high broken appointment rate, our policies will now be as follows:

1. The GNDC will call and attempt to confirm all appointments (usually two days prior). If we leave a message, we require a call back to confirm. If we do not receive verbal confirmation 24 hours prior to the scheduled time, **THE APPOINTMENT WILL BE CANCELED.**

2. If the GNDC attempts to confirm and appointment and the number is disconnected or unavailable, and we do not reviewed confirmation, **THE APPOINTMENT WILL BE CANCELED.**

3. Once a patient had three broken appointments, in order to obtain an appointment they must call the GNDC on a daily basis to check for future appointment availability

4. If you are more than 15 minutes late for your scheduled appointment we reserve the right to reschedule to another date and time.

I have read and understand the Clinic Policies for The Greater Nashua Dental Connection, INC., and agree to adhere to these policies.

*Name:*_____ *Date:* _____

THE GNDC RESERVES H RIGHT TO REFUSE TREATMENT TO ANY PATIENTS AND/OR ASSOCIATES WHO DISPLAY OR THRETEN UNRULY OR VIOLENT BEHAVIOR- NO EXCEPTIONS

31 CROSS STREET, NASHUA, NH 03064 • 603-879-9314 TEL / 603-879-9330 FAX

THE GREATER NASHUA
DENTAL CONNECTION

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the "Notice of Privacy Practices" and have been provided an opportunity to review it.

Patient_____Birthdate_____

Parent/Guardian_____

Signature_____ Date_____

31 Cross Street, Nashua, NH 03064 • 603-879-9314 tel / 603-879-9330 fax

APPENDIX C

SELF-DECLARATION OF INCOME REPORT

COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM

(Updated April 1, 2020)

Federal regulations require we obtain this information to document assistance is being provided to low and moderate-income households. The Participant/Guardian should complete this form indicating all persons residing within their household, regardless of whether or not they are related. The Grantee should retain this form for monthly reporting requirements as well as for on-site monitoring visits.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT SHARED WITH ANY OTHER AGENCIES

PARTICIPANT INFORMATION

PARTICIPANT STATUS: ☐ FAMILY ☐ INDIVIDUAL

Participant Name: _____

Address: _____ City, State, Zip Code: _____

ETHNICITY *(please select only one):*

☐ **Hispanic or Latino** ☐ **Not Hispanic or Latino**

RACE *(please select only one):* **Language Spoken** _____

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaska Native American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaskan Native ***and*** White
- ☐ Asian ***and*** White
- ☐ Black/African American ***and*** White
- ☐ American Indian/Alaskan Native ***and*** Black/African
- ☐ Other Multi-Racial: _____

HOUSEHOLD INFORMATION

i. Circle the total number of people living in your household.
ii. Circle the corresponding income level.

Household Size		(0-30%)	(31-50%)	(51-80%)	(Over 80%)
1		$0 – 23,350	$23,351 - $38,850	$38,851 - $54,950	$54,951 +
2		$0 - $26,650	$26,651 - $44,400	$44,401 - $62,800	$62,801 +
3		$0 - $30,000	$30,001 - $49,950	$49,951 - $70,650	$70,651 +
4		$0 - $33,300	$33,301 - $55,000	$55,001 - $78,500	$78,501 +
5		$0 - $36,000	$36,001 - $59,950	$59,951 - $84,800	$84,801 +
6		$0 - $38,650	$38,651 - $64,400	$64,401 - $91,100	$91,101 +
7		$0 - $41,300	$41,301 - $68,850	$68,851 - $97,350	$97,351 +
8		$0 - $44,120	$44,121 - $73,300	$73,301 - $103,650	$103,651 +

Check here if unemployed ☐ (please still circle household size)

I certify the above information is true and correct to the best of my knowledge.

Participant/Guardian: _____ **Date:** _____

(Original signature is required)