DENTISTRY FOR CHILDREN AND ADOLECENTS, ERIKA E. GABOR D.M.D
18525 SUTTER BLVD, SUITE #190, MORGAN HILL, CA 95037

CHILD'S DENTAL MEDICAL HISTORY **DATE: _____**

PATIENT'S NAME: _____
Last First Middle Initial Nickname Date of Birth

Reason for the visit: _____ please circle: male female

Referred to our office by**:** _____

Others siblings seen by our office: _____

FAMILY RECORD

Home Residence Address:_____
Street City, State Zip Code

Home Residence Phone Number**:** _____

FATHER'S FULL NAME: _____

Address (if different):_____ Phone #:_____

Occupation:_____ Employer: _____

Business Address: _____

Business Phone #: _____ E-mail Address: _____

Drivers License #: _____Social Security #:_____

Date of Birth: _____ Cell Phone #: _____

Dental Insurance Company: _____ Group #:_____

Dental Insurance Company Phone #: _____

Please circle appropriate status: single married divorced remarried

If remarried Spouse's full name: _____

Spouse's date of birth: _____

MOTHER'S FULL NAME _____

Address (if different): _____ Phone #:_____

Occupation: _____ Employer:_____

Business Address: _____

Business Phone #: _____ E-mail Address: _____

Drivers License #: _____ Social Security #:_____

Date of Birth: _____ Cell Phone #: _____

Dental Insurance Company: _____

Dental Insurance Company Phone #:_____

Please circle appropriate status: single married divorced remarried

If remarried Spouse's full name: _____

Spouse's date of birth: _____

Please list the name and telephone numbers of person(s) we can share your child's health information with in case of emergency or if anyone else other than you will be bringing your child to an appointment:

Name: _____ Phone #:_____

Name: _____ Phone #:_____

Name: _____ Phone #:_____

DENTAL HISTORY

Childs name: _____

1. Is this your child's first visit to the dentist? ……..…… yes no
2. If not first visit, date of last visit to the dentist: _____
3. Child's previous dentist: _____
   Address and Phone #: _____
4. Were any x-rays taken at the previous dentist visit? ……..… yes no
5. Has your child had an unfavorable experience in a previous dental office? ……..….. yes no
6. Have there been any injuries to your child's teeth or jaw- falls, blows chips, etc?. . . . . yes no
   Describe: _____ Date: _____
7. How does your child take fluoride? In vitamins_____, tablets_____, water_____, etc.?..... yes no
8. Does your child eat between meals? …… yes no
9. Does your child eat sweets, candy, juice, soda pop, or chewing gum? ..... yes no
10. When does your child brush his/her teeth? (Circle all that apply)

Upon arising After eating any food Right after meals Before going to bed

MEDICAL HISTORY (Circle appropriate answer)

1. Does your child have a health problem? _____ yes no
2. Is your child under the care of a physician? ..... yes no
   If yes, since when and why? _____
3. Name of your child's physician? _____ Phone# _____
4. Is your child receiving any medication? …… yes no
   If yes, what? _____
   Has your child ever taken Fosamax or any Biophosphonate? ..... yes no
5. Is your child allergic to penicillin, antibiotics or other drugs? …… yes no
   What? _____
6. Does your child have other allergies? Latex If yes, what? _____ yes no
7. Has your child had any serious illness? …… yes no
   If yes, what and when? _____
8. Has your child ever had surgery? _____ When? _____ For What? _____
9. Does your child have a heart murmur? ……... yes no
   If yes, does he/she need to be premedicated for dental treatment? ..... yes no
10. Has your child experienced severe or prolonged bleeding? …… yes no
11. Does your child have AIDS or has he/she tested HIV positive? ..... yes no
12. Has your child ever tested positive for hepatitis or TB? ..... yes no
13. Is your child adopted? ..... yes no
14. Is your child subject to nervous disorders? …… yes no

    Fainting Seizures Dizziness Behavior/Learning Problems ADD/ADHD
15. Does your child have frequent headaches? …… yes no
16. Has your child had a history of the following? (Please circle)

Diabetes	yes	no	Congenital Birth Defects	yes	no	Infections	yes	no
Heart Trouble	yes	no	Mental Retardation	yes	no	Epilepsy	yes	no
Asthma	yes	no	Eyesight Problems	yes	no	Speech Impaired	yes	no
Kidney Infection	yes	no	Cancer	yes	no	Hearing Loss	yes	no
Rheumatic Fever	yes	no	Cerebral palsy	yes	no	Liver Problems	yes	no
Latex Allergy	yes	no						

Comments or Concerns: _____

(1) I Certify That All Medical and Dental Information Provided Is Complete and Accurate.

Parent/Guardian's Signature:_____ **Date:** _____

Print Parent Full Name:_____

Dentist Signature:_____Date: _____

Child's Name: _____

(1) Financial Policy.

I understand that the complete financial responsibility for dental services rendered is with the parent or person responsible for the account whether or not there is dental insurance coverage. A monthly service charge of 1.65% (19.8% per annum) will be added to all unpaid account balances over 90 days. At least 24 hours notice of inability to keep an appointment is the expected. Otherwise, a reasonable fee for the time lost will be charged.

Person responsible for the account: _____

Parent/Guardian's signature: _____ Date: _____

Relationship to child: _____

(2) Dental Board Fact Sheet

I _____, Acknowledge that I have received a copy of the Dental Materials Fact Sheet dated October 1, 2002. This complies with the senate bill 134 that became effective January 1, 2002

Parent/Guardian's signature: _____ Date: _____

(3) Permit for Dental Services upon a Minor and Financial Responsibility

I, being the parent or guardian of _____ (child's name) do hereby authorize and request the performance of dental services upon this patient and authorize whatever procedures that the judgment of Dr. Gabor may dictate during the treatment. This may include the administration of local anesthetic, sedatives, or medications as deemed necessary by Dr. Gabor for the comfort and well being of the child, (You may request a written description of our procedure.) Your child's first visit will include an oral examination, x-ray diagnosis (when necessary), and a cleaning and fluoride treatment. You will be informed of all services and given a cost estimate before any other services are rendered for your child. At least a 24 hour notice of inability to keep appointment is expected, otherwise a reasonable fee for time lost will be charged. Our office is committed to meeting or exceeding the standards of infection control as mandated by OSHA, the CDC and the ADA.

Parent/Guardian's signature: _____ Date: _____

(4) HIPAA Privacy Authorization and Consent Agreements

I have received: Authorization for the disclosure of Protected Heath Information for treatment, payment or healthcare operations (#164.508(a)), Consent to the use and disclosure of Protected Health Information for treatment, payment or healthcare operations (#164.506(a)), and Acknowledgement of receipt of Information Practices Notice(#164.520(a)). I acknowledge and give my consent to use my Protected Health Information for the treatment of my child with Dr. Gabor.

Parent/Guardian's signature: _____ Date: _____

(5) Authorization for Signature on File

I, _____ (parent or guardian) and/or _____(name of insured) hereby authorize the office of Dr. Gabor to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependants through my employment with_____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office listed above; I have reviewed the treatment plan and fees. I agree to be responsible for all charges of dental services materials not paid by my dental benefit plan, unless Dr. Gabor has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim. This "Authorization" will be valid from this date and shall expire in one year. A photocopy of this document may act as an original.

_____ _____

Signature of Insured **Witnessed By**

_____ _____

Signature of Parent/Guardian **Today's Date**

(6) Permission to post names and photographs of patients on winner bulletin boards in our office.

Parent/Guardian's signature: _____

Notice of Privacy Practices Acknowledgement

Dr. Erika E. Gabor, DMD
18525 Sutter Blvd. Suite 190
Morgan Hill, CA 95037

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child's protected health information. I understand that this information will be used to:

(1) Plan and conduct treatment and follow up among multiple health care providers who may be involved in that treatment directly and indirectly.
(2) Obtain payment from third party payers.
(3) Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have read and received my *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I understand that Dr. Gabor's office has the right to change the *Notice of Privacy Practices* at any time. I understand that I may contact the office at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that the office restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I understand that Dr. Gabor's office is not required to agree to my requested restrictions; however, if we do agree, then we are bound to abide by such restrictions.

Patient Name: _____

Parent/Guardian Signature: _____

Relationship to Patient: _____

Date: _____

PHOTO CONSENT FORM

I hereby give Dr. Erika Gabor and any employees and/or agents of Dr. Erika Gabor the right and permission to use and/or publish photographs of me for art and promotional purposes including but not limited to: advertising, publicity, commercial, or display of use. Also, authorize my photos to be posted on social media such as Facebook, Instagram, and the office's official website.

Release of Claims
I hereby release and discharge Dr. Erika Gabor and all persons functioning under her permissions or authority from any legal or equitable claims including but not limited to the following: blurring of image(s), alteration, distortion or use in composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing materials.

Initial the following:

____ Yes, you may use my photos.

____ No, please do not use my photos.

_____

Name of Patient (Please Print)

_____

Parent/Guardian (Signature)

_____

Date

MEDICAL RELEASE
SPECIAL AUTHORIZATION FORM

I, _____, authorize the following name person/person(s) to authorize (Medical/Dental) treatment for my child/children by Erika E. Gabor, DMD. I allow Dr. Gabor and staff to share health information with the following person(s).

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives.

I understand that I may terminate this authorization form. I must notify Erika E. Gabor, DMD in writing regarding termination and effective date.

NAME OF PERSONAL REPRESENTATIVE	RELATIONSHIP
_____	_____
_____	_____
_____	_____

NAME OF CHILDREN	AGES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signed by: _____

Relationship to child:_____

Date: _____