Today's Date: _____ Sex: M or F

Patient's First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Favorite toy/hobby: _____ Primary language? _____

Birth Date: _____ **Age:** _____ Soc. Sec: _____ Medicaid ID: _____

If Student, where? _____ How did you hear about our office? _____

Does Child live with both parents? □Yes □No □Mother? □Father? □Guardian? _____

Responsible Party: (Parent, Legal Guardian, or Patient if age 18 or older)

Mother's First Name: _____ Last Name: _____ MI: _____ DOB: _____

Father's First Name: _____ Last Name: _____MI: _____ DOB: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____Home Ph#: _____

Work #: mom or dad: _____ Ext: _____ Cellular#: mom or dad: _____

Cellular#: mom or dad: _____ other contact #:_____

Alternate Contact Information: (someone not living in your home, friend, family member, neighbor)

Name: _____ Relation to Patient: _____

Home Ph#: _____ Work Ph#: _____ Cellular#:_____

Dental History Is this your child's first visit to the dentist? □ Yes □ No If no, date and reason of last dental visit_____

Date of last dental exam_____ cleaning_____ X-rays_____ Office_____

Has your child been seen here before: □ Yes □ No When:_____

Has your child been having a specific problem? □ Yes □ No Describe: _____

Has your child experienced any unfavorable reaction from any previous dental or medical care □ Yes □ No

Describe: _____

How do you describe your child's dental health? □ Good □ Fair □ Poor

Do you feel your child may need Nitrous Oxide? □ Yes □ No or IV Sedation? □ Yes □ No

Has your child ever been under General Anesthesia? □ Yes □ No If yes, please explain_____

Medical Pediatrician/doctor's name: _____ Phone Number_____ Last physical exam_____

Does your child have any medical problems? _____

Is the child under a physician's care now □ Yes □ No explain_____

Is the child taking any medications, pills, or drugs □ Yes □ No list_____

Has the child ever been hospitalized □ Yes □ No reason/dates_____

Is the child allergic to any of the following?

Does your child have any allergies? □ Yes □ No

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Anesthetics

□ Other If yes, please explain: _____

Does the child have or has the child previously had any of the following? Indicate YES with a check mark (√)

□ ADD	□ Diabetes	□ Herpes	□ Psychiatric Care
□ ADHD	□ Down Syndrome	□ Jaundice	□ Rheumatic Fever
□ AIDS/HIV Positive	□ Drug Addiction	□ Kidney Disease or Dialysis	□ Sickle Cell Disease
□ Anemia	□ Epilepsy or Seizures	□ Malignancies	□ Thyroid Disease
□ Arthritis/Gout	□ Fainting Spells/Dizziness	□ Measles/Mumps	□ Tonsillitis
□ Asthma	□ Heart Murmur	□ Mental Disability/Handicap	□ Tuberculosis
□ Autism	□ Heart Trouble/Disease	□ Multiple Sclerosis	□ Other_____
□ Cancer	□ Hemophilia	□ OCD	_____
□ Chicken Pox	□ Hepatitis A	□ Prolonged bleeding	_____
□ Cerebral Palsy	□ Hepatitis B or C	□ Prosthetic valves/joints	_____

AUTHORIZATION: I hereby authorize the doctor(s) and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care of my child as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Child's Parent or Guardian Signature X_____ Date:_____ reviewed by Doctor X_____ Date:_____

MEDICAL HISTORY UPDATES FOR SUBSEQUENT VISITS

I have read my child's MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Child's age	EXCEPTIONS	Parent/Guardian Signature	Reviewed by
_____	_____	None□_____	DR._____	
_____	_____	None□_____	DR._____	
_____	_____	None□_____	DR._____	
_____	_____	None□_____	DR._____	

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Accent Dental

Kristiane Naegler, DMD
General Dentistry

Michael Todd, DMD
General Dentistry

Victoria Dzundzev, DMD
General Dentistry

I, the undersigned, grant permission to any physician, dentist, clinic or hospital to release to Accent Dental all information concerning my present and/or past medical or dental conditions and treatments. Also for Accent Dental Center to release all information concerning my present and/or past medical or dental condition and treatments to any other physician, dentist, clinic, hospital, or head start center.

Patient's Name_____

Parent or Legal
Guardian Name_____

Signature_____ Date_____

MC+ID# (if applicable) _____

Welcome to Accent Dental Center. We are a private practice established in 2002 to serve the needs of children in the nine county Eastern areas. In order to serve you better we would like you to take this opportunity to review our office policies.

Late Policy

As a courtesy to all patients we reserve the right to reschedule any patient who is more that fifteen minutes late for an appointment. For patients driving a considerable distance to their appointments we recommend you allow yourself and additional 30 minutes for unforeseen circumstances (car trouble, lost, etc.). Due to the high number of patients that live outside St. Louis County we cannot make exceptions for patients that drive long distances.

Cancellation/Missed Appointment Policy

We kindly ask that you give our office at least 24 hours advance notice prior to canceling your appointment. Patients that give 24 hours notice are given priority when being rescheduled. If you have not called 24 hours in advance to cancel your appointment, and you wish to reschedule, you will be given the next available appointment. Patients that miss their appointment without calling to cancel will have their missed appointment indicated in their record. Three recorded missed appointments in a 1 year time period may result in dismissal from the practice. This means that you will not be seen by **Accent Dental Center**, and will have to receive care from another dentist.

Parents/Guardians With Children

Accent Dental Center allows a parent to be present with a child during the child's 1st visit only. Due to space limitations we will only allow **ONE** parent to accompany the child to the treatment room. If the parent is with additional children, then the parent will need to stay in the waiting room with the other children. If you are bringing more than one child to the appointment we recommend you bring another responsible adult to watch the additional children while you accompany your child to the treatment room. We **cannot** be responsible for children left unattended in the waiting room. ***A parent or legal guardian is required to be present when a minor presents for any visit.*** Legal guardians **must** supply proof of legal guardianship (not power of attorney) before **Accent Dental Center** will see the child. Only a parent or legal guardian may sign for the treatment of a minor therefore treatment will not be rendered to minors without written signature of parent or guardian; in this situation the minor will be rescheduled.

Pregnant Patients

Please inform the front desk if you are currently pregnant. Pregnant patients require a consult with the obstetrician prior to treatment.

General Policies

*Food and drink are not permitted in the waiting room.
*Restrooms are located at the main entrance to the building. If you need to leave the waiting room momentarily and you are waiting for your appointment, please advise the front desk. If the patient is not in the waiting room when their name is called; we will move on to the next patient.
*Shoes are required at all times.
***Accent Dental Center** does not tolerate abusive or disruptive behavior or foul language. Patients exhibiting such behavior will be dismissed from the practice. Threats are taken seriously and will be turned over to the St. Louis Police Department.

I acknowledge I have read and understand the above policies, and I agree to comply with these policies. I also understand that if I fail to comply with these policies I may be dismissed as a patient of **Accent Dental Center**.

Patient/Parent/Guardian: _____Date___/___/___
(Signature)

Patient/Parent/Guardian: _____Date___/___/___
(Print)