Patient Information

Child's Name: _____
Last First MI Nickname

☐Male ☐ Female Date of Birth: _____ Child's Social Security #: _____

Hobbies/Pets: _____

Address: _____

City: _____ State: ____ Zip Code: _____ Home Phone: _____

Names and ages of any other children in the family: _____

Do parents live together? ☐ Yes ☐ No If not, with whom does the child live? _____

Primary Dental Insurance

Policy Holder: _____ Relationship to patient: _____

Policy Holders Social Security #: _____ Date of Birth: _____

Insurance Company: _____ Employer: _____

Policy #:_____Group #: _____ Member ID # _____

Insurance Company Phone #: _____

Is child covered by any other dental insurance plans (including Medicaid)? ☐Yes ☐ NO

Secondary Dental Insurance

Policy Holder: _____ Relationship to patient: _____

Policy Holders Social Security #: _____ Date of Birth: _____

Insurance Company: _____ Employer: _____

Policy #:_____Group #: _____ Member ID # _____

Dental History

Is this your child's first visit to the dentist? ☐Yes ☐No If no, please give date of last dental care: _____ Previous Dentist: _____

Do you have a copy of your child's dental records? ☐Yes ☐No

Is your child on a bottle? ☐Yes ☐No If no, at what age was it discontinued? _____

Is your child a thumb/finger sucker or ever used a pacifier? ☐Yes ☐No Age discontinued _____

Is your primary source of water from a well? ☐Yes ☐No

Does your child take fluoride in any form? ☐Toothpaste ☐Rinse ☐Tablet ☐City Water/Nursery Water

Has your child had any traumatic injury to his/her teeth? ☐Yes ☐No If yes, please explain:

_____

Has your child had any problems with previous dental treatment? ☐Yes ☐No If yes, please explain:

_____

Does your child have any dental conditions you are concerned about today? ☐Yes ☐No If Yes, please explain:

_____

Medical History

Child's pediatrician: _____ Phone Number: _____

Date of last visit:_____

Has your child been hospitalized or had surgery since birth? ☐Yes ☐No If Yes, please explain:

_____

Does your child have any special needs? ☐Yes ☐No Please list: _____

Any other medical conditions or concerns? _____

For patients 14 and over: Any recreational use of tobacco, alcohol or history of substance abuse? ☐Yes ☐No

If yes, please provide additional details: _____

Cont'd- Patient Name:_____

Has your child ever had any of the following? (Please select yes or no for each condition)

Abnormal Bleeding	☐Yes ☐No	Kidney Disorder	☐Yes ☐No
ADD/ADHD	☐Yes ☐No	Learning Disabilities	☐Yes ☐No
AIDS/HIV	☐Yes ☐No	Liver Problems	☐Yes ☐No
Anemia	☐Yes ☐No	Lung Disease	☐Yes ☐No
Asperger's	☐Yes ☐No	Mental/Emotional Disorder	☐Yes ☐No
Asthma	☐Yes ☐No	Muscular Dystrophy	☐Yes ☐No
Autism	☐Yes ☐No	Nose/Throat Disorder	☐Yes ☐No
Cancer/Tumors	☐Yes ☐No	Premed Needed	☐Yes ☐No
Cerebral Palsy	☐Yes ☐No	History of RSV	☐Yes ☐No
Cleft Lip/Palate	☐Yes ☐No	Respiratory Problems	☐Yes ☐No
Diabetes	☐Yes ☐No	Sickle Cell Disease	☐Yes ☐No
Downs Syndrome	☐Yes ☐No	Sickle Cell Trait	☐Yes ☐No
Epilepsy/Convulsions	☐Yes ☐No	Sinus Problems	☐Yes ☐No
Heart Condition/Murmur	☐Yes ☐No	Speech Problems	☐Yes ☐No
Hemophilia	☐Yes ☐No	Stomach Disorder	☐Yes ☐No
Hepatitis	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Hearing Impaired	☐Yes ☐No	Tuberculosis	☐Yes ☐No
		Vision Problems	☐Yes ☐No

If any yes answers above please explain or give additional details: _____

_____

Please list all current medications-prescription, non-prescription and supplements. _____

_____

Allergies

☐None ☐ Penicillin/Amoxicillin ☐Codeine ☐Latex ☐ Ibuprofen ☐Anesthetic

☐Other (Please list): _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I am the parent, guardian or personal representative of this patient and have the legal right to authorize medical and dental care for this child. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical or dental status. I authorize the dentist and staff of Center For Pediatric Dentistry to perform the necessary dental services my child may need. I also authorize the dentist and staff of Center For Pediatric Dentistry to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I agree to remain on the premises while my child is being treated. I understand that my insurance carrier may pay less that the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf. I also agree that any fees incurred on this account for finance charges, collection actions or delayed payment by myself or the insurance company will be my responsibility.

Signature of Parent/Guardian: _____Date:_____

Printed Name of person signing: _____ Relationship to patient: _____

Does this person have the legal right to make health care decisions for the patient listed above? ☐Yes ☐No

Reviewed and signed by Dr: _____ **Date:** _____