

Patient Information

Child's Name: _____

Last First MI Preferred Name

 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 HistoryIs 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 NoIs 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 NoDoes your child take fluoride in any form? Toothpaste Rinse Tablet City Water/Nursery WaterHas 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: _____

For ALL patients, has your child ever had any of the following? (Please select yes or no for each condition)

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