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Pediatric Dentistry

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CHILD'S FULL NAME			
BIRTHDATE	AGE	WEIGHT	SEX
STREET	CITY	STATE	ZIP
HOME PHONE			
SCHOOL	DISTRICT	GRADE	
NAME(S) AND AGE(S) OF SIBLING(S)		HAVE WE SEEN YOU IN THIS OFFICE BEFORE? YES ___ NO ___	
FAVORITE PLAYMATE, PET, TOY, HOBBY, OR SPORT			

HOW, OR FROM WHOM DID YOU LEARN ABOUT OUR PRACTICE? \_\_\_\_\_

IS THIS YOUR CHILD'S FIRST VISIT TO A DENTIST? YES \_\_\_ NO \_\_\_

If not, please share with us why you wish to make a change. \_\_\_\_\_

\_\_\_\_\_ Date of last visit \_\_\_\_\_ Dentist \_\_\_\_\_

HOW WOULD YOU DESCRIBE YOUR CHILD'S PREVIOUS MEDICAL OR DENTAL EXPERIENCES? \_\_\_\_\_

PLEASE DISCUSS YOUR EXPECTATIONS AND DESIRES REGARDING YOUR CHILD'S DENTAL CARE. \_\_\_\_\_

DOES YOUR CHILD HAVE A HISTORY OF ANY ORAL HABITS? (Mouthbreathing, Thumbsucking, etc.) YES \_\_\_ NO \_\_\_

If so, please explain: \_\_\_\_\_

DOES YOUR CHILD HAVE REGULAR MEDICAL EXAMINATIONS? YES \_\_\_ NO \_\_\_

PHYSICIAN \_\_\_\_\_ Date of last exam \_\_\_\_\_ YES \_\_\_ NO \_\_\_

IS YOUR CHILD TAKING ANY MEDICATION(S) NOW? YES \_\_\_ NO \_\_\_

If so, please explain: \_\_\_\_\_

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION TO ANY MEDICATION(S)? YES \_\_\_ NO \_\_\_

If so, please explain: \_\_\_\_\_

DOES YOUR CHILD HAVE ANY KNOWN PHYSICAL OR MEDICAL CONDITION? OR SEE A SPECIALIST FOR ANY REASON? YES \_\_\_ NO \_\_\_

If so, please explain: \_\_\_\_\_

PHYSICIAN: \_\_\_\_\_ DATE OF LAST EXAM: \_\_\_\_\_

FOR COMPLETENESS OF MEDICAL HISTORY IS YOUR CHILD ADOPTED OR FOSTER CHILD? YES \_\_\_ NO \_\_\_

PLEASE INDICATE ANY CONDITION(S) YOUR CHILD HAS HAD:

- |                                      |                                      |   |                                    |   |
|--------------------------------------|--------------------------------------|---|------------------------------------|---|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Rheumatic Fever    | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Epilepsy    | <input type="checkbox"/> Measles     | <input type="checkbox"/> Heart Condition    | <input type="checkbox"/> Anemia    | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Asthma      | <input type="checkbox"/> Blood Disorder     | <input type="checkbox"/> Tumors    | <input type="checkbox"/> Other          |
| <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Mumps       | <input type="checkbox"/> Emotional Problems |                                    |   |

PLEASE NOTE ANY SPECIAL INFORMATION ABOUT YOUR CHILD: \_\_\_\_\_

# FAMILY HISTORY

FATHER'S FULL NAME		PREFERRED NAME	
HOME ADDRESS IF DIFFERENT FROM CHILD'S		BIRTHDATE	
		EMAIL	
PHONES: HOME ( )	WORK ( )	CELL ( )	
SOCIAL SECURITY #	EMPLOYER	HOW LONG?	

MOTHER'S FULL NAME		PREFERRED NAME	
HOME ADDRESS IF DIFFERENT FROM CHILD'S		BIRTHDATE	
		EMAIL	
PHONES: HOME ( )	WORK ( )	CELL ( )	
SOCIAL SECURITY #	EMPLOYER	HOW LONG?	

CHILD'S PARENTS ARE: MARRIED \_\_\_ DIVORCED \_\_\_ SEPARATED \_\_\_

IF PARENTS DO NOT LIVE TOGETHER, WITH WHOM DOES CHILD LIVE? \_\_\_\_\_

NAME OF FRIEND OR RELATIVE WHO MAY BE CONTACTED IN CASE OF EMERGENCY:

\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

DO YOU HAVE DENTAL INSURANCE? \_\_\_\_\_

INSURED'S NAME _____	INSURED'S DATE OF BIRTH _____
INSURED'S SOCIAL SECURITY # _____	
EMPLOYER: _____	EMPLOYER PHONE # _____
INSURANCE COMPANY NAME _____	INSURANCE COMPANY PHONE _____
INSURANCE COMPANY ADDRESS _____	
GROUP # _____	

IT IS OUR POLICY TO INFORM YOU THAT PAYMENT OF FEES FOR PROFESSIONAL SERVICES IS EXPECTED AT THE TIME OF TREATMENT BY THE PARENT OR GUARDIAN IN ATTENDANCE. WE ACCEPT PAYMENT BY CHECK OR CASH. FOR THOSE WISHING THE CONVENIENCE OF EXTENDED PAYMENT PLANS, WE ALSO ACCEPT PAYMENT BY MASTERCARD OR VISA OR DISCOVER OR AMERICAN EXPRESS.

BECAUSE THIS CHILD IS A MINOR, IT BECOMES NECESSARY THAT PERMISSION IS OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY NECESSARY DENTAL TREATMENT IS BEGUN. AUTHORIZATION IS HEREBY GRANTED AS SUCH. FURTHERMORE, I WILL BE RESPONSIBLE FOR ANY FEES FOR PROFESSIONAL SERVICES RENDERED ON BEHALF OF THIS CHILD.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

RELATIONSHIP TO CHILD \_\_\_\_\_