PATIENT INFORMATION – PEDIATRIC DENTISTRY

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WOODHILL DENTAL SPECIALTIES - SPECIALISTS IN PEDIATRIC DENTISTRY & ORTHODONTICS

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PERSONAL HISTORY

CHILD'S FULL LEGAL NAME		PREFERRED NAME		
BIRTHDATE	AGE	HEIGHT	WEIGHT	SEX
STREET		CITY	STATE	ZIP
MAIN CONTACT TELEPHONE NUMBER		MAIN CONTACT EMAIL ADDRESS		
SCHOOL		SCHOOL DISTRICT		GRADE
FULL NAME OF RESPONSIBLE PARTY		RELATIONSHIP TO PATIENT		
CELL PHONE NUMBER OF RESPONSIBLE PARTY		OCCUPATION OF RESPONSIBLE PARTY		
MARITAL STATUS OF RESPONSIBLE PARTY (CHECK ONE): ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOWED				
ADDRESS IF DIFFERENT FROM ABOVE				
SPOUSE'S / SIGNIFICANT-OTHER'S FULL NAME		RELATIONSHIP TO PATIENT		
CELL PHONE NUMBER		OCCUPATION		
ADDRESS IF DIFFERENT FROM ABOVE				
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE		

SOCIAL HISTORY

HOW, OR FROM WHOM DID YOU LEARN ABOUT OUR PRACTICE?
HAVE WE SEEN YOU OR ANYONE ELSE IN YOUR FAMILY IN OUR OFFICE BEFORE? IF SO, PLEASE TELL US WHO.
YOUR CHILD'S FAVORITE PLAYMATE, PET, TOY, HOBBY, OR SPORT

DENTAL INSURANCE

NAME OF POLICYHOLDER (INSURED)	INSURED'S DATE OF BIRTH	INSURED'S SOCIAL SECURITY NUMBER
EMPLOYER	EMPLOYER'S PHONE	
INSURANCE COMPANY'S NAME	INSURANCE COMPANY'S PHONE	
INSURANCE COMPANY'S ADDRESS	GROUP NUMBER	MEMBER ID NUMBER

DENTAL HISTORY

IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST?	☐ **YES** ☐ **NO**
IF NOT, WHEN WAS THE DATE OF YOUR CHILD'S LAST VISIT?	
DID THE DENTIST TAKE ANY X-RAYS AT THAT VISIT?	☐ **YES** ☐ **NO**
HOW WAS YOUR CHILD'S EXPERIENCE AT THAT VISIT?	
IF YOUR CHILD HAS ANY ORAL HABITS, PLEASE LIST THEM HERE:	
DO YOU HAVE A CHIEF CONCERN THAT YOU WOULD LIKE ADDRESSED AT THIS VISIT?	

MEDICAL HISTORY

WHO IS YOUR CHILD'S PEDIATRICIAN?	PEDIATRICIAN'S PHONE NUMBER:
DOES YOUR CHILD HAVE REGULAR MEDICAL EXAMINATIONS?	☐ **YES** ☐ **NO**
DOES YOUR CHILD RECEIVE HIS/HER ROUTINE VACCINATIONS?	☐ **YES** ☐ **NO**
IF NOT, PLEASE ELABORATE:	
DOES YOUR CHILD HAVE ANY ALLERGIES?	☐ **YES** ☐ **NO**
If YES, PLEASE LIST HIS/HER ALLERGIES:	
IS YOUR CHILD TAKING ANY MEDICATIONS OR HERBAL SUPPLEMENTS?	☐ **YES** ☐ **NO**
IF YES, LIST MEDICATIONS AND HERBAL SUPPLEMENTS:	
HAS YOUR CHILD EVER HAD A SERIOUS ILLNESS OR ACCIDENT, REQUIRED SURGERY OR HAD A PREVIOUS HOSPITALIZATION? IF SO, PLEASE ELABORATE:	
DOES YOUR CHILD HAVE ANY SPECIAL NEEDS OR REQUIRE SPECIAL ACCOMMODATIONS? IF SO, PLEASE ELABORATE:	

INDICATE ANY MEDICAL CONDITIONS YOUR CHILD CURRENTLY HAS OR HAD IN THE PAST, AND ELABORATE BELOW:

☐ HEART MURMUR	☐ STOMACH OR OTHER DIGESTIVE DISORDERS
☐ HIGH/LOW BLOOD PRESSURE	☐ LIVER OR KIDNEY DISORDERS
☐ CIRCULATORY SYSTEM ISSUES	☐ THYROID OR OTHER GLANDULAR ISSUES
☐ RHEUMATIC FEVER OR OTHER HEART CONDITIONS	☐ TUMORS AND/OR CANCER
☐ EPILEPSY OR OTHER SEIZURE DISORDERS	☐ AIDS OR OTHER SYSTEMIC INFECTIONS
☐ NERVOUSNESS/ANXIETY/EMOTIONAL DISORDERS	☐ DERMATOLOGICAL SENSTIVITIES/CONDITIONS
☐ COGNITIVE OR OTHER DEVELOPMENTAL DELAYS	☐ EYE OR OTHER VISION-RELATED ISSUES
☐ ASTHMA OR OTHER RESPIRATORY DISORDERS	☐ PREGNANT OR ON BIRTH CONTROL
IF YOU CHECKED ANY OF THE CONDITIONS ABOVE, PLEASE ELABORATE:	

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, VISA, 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	RELATIONSHIP TO CHILD	DATE