PEDIATRIC DENTISTRY & ORTHODONTICS FOR ALL AGES

Building Smiles, Faces, & Self-Esteem the Fun, Gentle, & Easy Way

Child's Last Name________________________ **First**___________________ **Nickname** ____________________
Address____ Home Phone__________________
City, State, Zip____ Gender: ( )M ( )F
Date of Birth_______________ Ins. ID # _____________________ Soc. Security #__________________
Favorite Interests/Hobbies____
Physician/Pediatrician ____ Phone __________________
Address ________________________________ City ___________________________ Zip code________
Date of Last Physical Exam___________________________ Results_______________________________

( )Mother ( )Stepmother ( )Guardian
Last Name________________________________ First ___________________________________
Address _________________________________ Home Phone______________________________
City, State, Zip____________________________ Business Phone ____________________________
Employer _________________________________ Soc. Security#____________________________
Occupation _______________________________ Date of Birth ____________________________
E-mail address ____________________________ Cell Phone________________________________
Marital Status: ( ) Married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed ( ) Domestic Partner

( )Father ( )Stepfather ( )Guardian
Last Name________________________________ First_____________________________________
Address _________________________________ Home Phone______________________________
City, State, Zip____________________________ Business Phone ____________________________
Employer _________________________________ Soc. Security#____________________________
Occupation _______________________________ Date of Birth____________________________
E-mail address ____________________________ Cell Phone________________________________
Marital Status: ( ) Married ( )Single ( )Separated ( )Divorced ( ) Widowed ( ) Domestic Partner

Where would you like your appointment confirmed? ( ) Home phone ( ) Work phone ( ) Cell phone

Primary Dental Insurance
Insured's Name__________________________________
Relationship to patient ___________D.O.B.__________
Soc. Security#___________________________________
Employer_______________________________________
Insurance Co.____________________________________
Insurance ID#____________________________________
Group#____
Insurance Co. Address___________________________
Insurance Co. Phone#____________________________

Secondary Dental Insurance
Insured's Name __________________________________
Relationship to patient ___________D.O.B. ___________
Soc. Security#____________________________________
Employer____
Insurance Co. _____________________________________
Insurance ID#_____________________________________
Group# ___________ Employee#___________________
Insurance Co. Address_____________________________
Insurance Co. Phone#______________________________

Are there any dental concerns? ( )No ( )Yes, please explain____

Were you referred for orthodontic reasons or do you have any smile or bite concerns?? ( )No ( )Yes, please explain
____

Whom may we thank for referring you? ____

Financially Responsible Party: ( )Father ( )Stepfather ( ) Mother ( )Stepmother ( )Other, please list__________________________

Last Name___________________________________ First____________________________
Address_____________________________________ City_____________________________
State_____________ Zip ____________Home Phone ____________________________
Cell Phone________________________Business Phone __________________________
E-Mail Address ____
Drivers License#____________________________________ Soc. Security#________________________________

I am aware that payment is expected at the time services are rendered. I agree to pay Pediatric Dentistry for those services. I give Pediatric Dentistry permission to contact me at all phone numbers listed, for financial reasons. Any service charges, collection or legal fees which arise from my failure to pay for services rendered will be paid by the financially responsible party.

____ ________________________
Signature of Financially Responsible Parent/Guardian Date

PATIENT MEDICAL HISTORY

	Yes	No		Yes	No
Any injuries to the mouth?	☐	☐	Do you have fluoridated water?	☐	☐
Using a bottle?	☐	☐	Is fluoride taken in any other form?	☐	☐
Bottle used in bed?	☐	☐	Does child brush 2 times per day?	☐	☐
Thumb/finger sucking?	☐	☐	Do you supervise brushing?	☐	☐
Using a pacifier?	☐	☐	Any unhappy dental visits?	☐	☐

	Yes	No	If "Yes" please explain
Grinding of teeth?	☐	☐	______
TMJ (jaw joint) problems?	☐	☐	______
Currently under the care of a physician	☐	☐	______
Taking any medications or drugs?	☐	☐	______
History of a heart murmur?	☐	☐	______
History of prolonged bleeding ?	☐	☐	______
Ever been hospitalized or had surgery?	☐	☐	______
Is there a family history of dental issues? (Ex. Missing teeth, extra teeth, etc.)	☐	☐	______
Allergic to penicillin?	☐	☐	______
Allergic to any other medications?	☐	☐	______
Any other allergies such as latex, pollen?	☐	☐	______

Please check if there has ever been any history of the following:

Pre-medication prior to dental appointments? ( )Yes ( ) No

	Yes	No		Yes	No		Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Cancer	☐	☐	Disabilities	☐	☐	HIV/AIDS	☐	☐	Mumps	☐	☐
Acid Reflux	☐	☐	CCD	☐	☐	Down Syndrome	☐	☐	Kidney Disease	☐	☐	Non-Verbal	☐	☐
Autistic	☐	☐	Celiac Disease	☐	☐	Epilepsy	☐	☐	Lactose Intolerant	☐	☐	PDD- NOS	☐	☐
Anemia	☐	☐	Cerebral Palsy	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Rett's Disorder	☐	☐
Asperger's	☐	☐	Chicken Pox	☐	☐	Feeding Tube	☐	☐	Measles	☐	☐	Shunts/Prostheses	☐	☐
Asthma	☐	☐	Cleft Palate	☐	☐	Hearing/Speech	☐	☐	Rheumatic Fever	☐	☐	Thyroid Disease	☐	☐
Behavior Problems	☐	☐	Convulsions	☐	☐	Heart Defect	☐	☐	Mental Retardation	☐	☐	Tuberculosis	☐	☐
Bi–Polar Disorder	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Mononucleosis	☐	☐	Sexually Transmitted Diseases	☐	☐

If "Yes" to any of the above, please give a short explanation: ______

Please describe any current medical treatment including drugs, pending surgery, recent injury, special needs, or any other information that we should be aware of?

______

CERTIFICATION AND AUTHORIZATION

I have answered these questions to the best of my knowledge. I understand that it is my responsibility to inform the dental office of any changes or updates on my childs health. I authorize Pediatric Dentistry to perform any necessary dental services that my child might need.

______ Signature of Parent/Guardian #1 ______ Date

______ Signature of Parent/Guardian #2 ______ Date