

Pediatric Dental Specialists

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| | | | | |
|--------------|----------|-----|-----|-----|
| Child's Name | Nickname | Sex | Age | DOB |
|--------------|----------|-----|-----|-----|

| | | |
|--------|--------|------------------|
| Weight | Height | Reason for Visit |
|--------|--------|------------------|

Who referred you to our office (we wish to thank them): _____

MEDICAL HISTORY

Child's Physician

Date of Last Visit (Month/Year)

-
- | | Yes | No |
|--|------------|-----------|
| 1. Is your child presently under the care of a physician for any medical problems? | _____ | _____ |
| 2. Was your child premature? How many weeks? _____ | _____ | _____ |
| 3. Is your child taking any medications? What? _____ | _____ | _____ |
| 4. Has your child ever been hospitalized or had surgery? | _____ | _____ |
| 5. Is your child allergic to any food or medications? What? _____ | _____ | _____ |
| 6. Has any member of your family had a problem with local or general anesthesia? | _____ | _____ |
| 7. Name of pharmacist: _____ Phone #: _____ | | |
-

Has your child had a history of: (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Painful swollen joints | <input type="checkbox"/> Brain Injuries | <input type="checkbox"/> Kidney/Liver Disease |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma/Hay Fever | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Drug Sensitivities | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Bronchopulmonary Disease | <input type="checkbox"/> Hives/Skin Rashes |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Other _____ | | |
-

Does your child have any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pain in Jaw Muscles | <input type="checkbox"/> Grinding/Clenching |
| <input type="checkbox"/> Earaches with no infection | <input type="checkbox"/> Sore or Painful Teeth |
| <input type="checkbox"/> Stiffness or itching of the ears | <input type="checkbox"/> Unable to open mouth wide |
| <input type="checkbox"/> Scoliosis (curvature of spine) | <input type="checkbox"/> Popping/clicking noises when opening mouth |

****Please let us know if you have additional information or concerns about your child****

DENTAL HISTORY

Child's first visit? (Month/Year) Previous Dentist City Date of Last Visit

Any History of: Nursing Bottle Habits Lip Sucking
 Mouth Breathing Thumb Sucking
 Nail Biting Pacifier
 Finger Sucking

Any injuries to your child's teeth or jaws? _____

Has your child experienced any unfavorable reaction from previous medical or dental care?

If so, please explain: _____

How do you think your child will react toward the dentist? _____

How often does your child brush? _____ Is it supervised? _____ By Whom? _____

Is dental floss used? _____ Does your child receive fluoride supplements? _____

FAMILY INFORMATION

Mailing Address City Zip Code Home Phone Number

Father's Full Name SSN Drivers License # Occupation

Employed by Business Phone # Cell Phone #

Mother's Full Name SSN Drivers License # Occupation

Employed by Business Phone # Cell Phone #

In case of emergency, name and phone # of someone who will always know your whereabouts:

Name: _____ Phone: _____

INSURANCE AND FINANCIAL RESPONSIBILITY

Is your child covered by a dental insurance plan? **YES** **NO**

Name of parent insured: _____ Employed by: _____

Insured SSN: _____ Insured DOB: _____ Name of Insurance Company: _____

Insurance Mailing Address: _____

Group or Policy #: _____ Person Responsible for Child's Account: _____

Member ID # (if applicable): _____

Payment is expected for service rendered at the time of service. The permission of the parent or guardian is necessary for dental treatment of a minor. I hereby give the doctors permission to use such measures necessary in their professional judgment to render the best dental treatment for my child. I also give my permission for photographs for diagnosis, treatment planning and teaching to be made. I certify that this information is true and correct to the best of my knowledge. I will notify you of changes in my child's health status or the above information. I understand that insurance claims are filed electronically. This is acceptable to me. I understand my privacy rights (HIPPA) and how my information can be used.

Signature: _____ Relationship to Child: _____ Date: _____