pediatric dental specialists®
Johnnie L. Hunt, D.D.S. and Brooke M. Wood, D.D.S.

Child's Name_____ Gender (circle one): Male Female

Nickname_____ Birthday ____/_____/_____

How did you hear about our office? _____

MEDICAL HISTORY

Child's Physician _____Telephone ( ) _____

	YES	NO
1. Is your child presently under the care of a physician now?	___	___
2. Was your child premature? How many weeks? _____	___	___
3. Is your child currently taking any medications daily? Please List: _____	___	___
4. Has your child ever been hospitalized or had surgery? Please List: _____	___	___
5. Is your child allergic to any food, medications, latex, etc? Please List: _____	___	___
6. Does your child require antibiotic premedication before dental visits?	___	___

Has your child had a history of the following? (Check any that apply)

___Anemia	___Asthma or Hay Fever	___AIDS/HIV
___Cancer	___Behavioral/Learning Problems	___Cerebral Palsy
___Heart Murmur/MVP	___Developmentally Delayed	___Hepatitis
___Diabetes	___Congenital Birth Defects	___Seizures
___Respiratory Problems	___Liver Problems	___Mouth Breathing/ Snoring
___Rheumatic Fever	___Severe or difficulty breathing	___Hearing Loss
___Speech Impairment	___Stomach Ulcers	

Other: _____

DENTAL HISTORY

	YES	NO
1. Is this your child's first visit to a dentist? Who was your child's previous dentist? _____	___	___
2. Does your child go to bed with juice or milk?	___	___
3. Does your child suck their thumb/finger or use a pacifier?	___	___
4. Does your child receive fluoride supplements?	___	___

5. How do you feel your child will react to the dentist? _____
6. How often does your child brush his/her teeth? _____
7. Do you have any concerns about your child's teeth? _____

PATIENT INFORMATION

Mailing Address City State Zip Code

_____

Home Phone Number **Email address**

_____

Father's full name SSN (Required unless 100%paid on date of service) Occupation

_____

Father's cell phone Father's business phone

_____

Mother's full name SSN (Required unless 100%paid on date of service) Occupation

_____

Mother's cell phone Mother's business phone

_____

DENTAL INSURANCE INFORMATION (RESPONSIBLE PARTY)

Name of Insured_____ Birth date____/____/_____

Name of Employer_____ Insurance Company_____

Insurance Company Address_____ _____City_____State_____Zip_____

**Member ID_____

**Group/Policy#_____

HIPPA PRIVACY AND FINANCIAL RESPONSIBILITY AGKNOWLEDGEMENT

Please initial the following: Initial

I have read and understand the Hippa Notice of Privacy Practices given to me: _____

I have read and understand the Financial Policy given to me: _____

Payment is expected on the date 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 the 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.*

Signature_____ Relationship to Child_____ Date_____