pediatric dental specialists®
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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**

_____

Guardian (1) Full Name Relationship to patient SSN (Required unless 100%paid on date of service)

_____

Cell phone Occupation

_____

Guardian (2) Full Name Relationship to patient SSN (Required unless 100%paid on date of service)

_____

Cell phone Occupation

_____

## 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.

## MISSED APPOINTMENT POLICY

If for any reason you need cancel or change an appointment, it is important that you give our office at least a 24 hour notice, otherwise it will be considered a missed appointment. We reserve the right after missed appointments to request pre-payment prior to rescheduling. Two or more missed appointments will result in dismissal from our practice.

**---I have read the policies above. I understand and agree to abide by the listed terms.---**

Signature_____ Relationship to Child_____ Date_____