

*Your family's best interest is our only interest!*

**Pediatric Patient Information** (all information given is confidential)

Today's Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Patient's Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone Number (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

Patient's Gender\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

Name of Person Responsible for this Account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_

Home Phone Number (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Cell Phone Number (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver's License Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Number (\_\_\_\_\_) \_\_\_\_\_\_-\_\_\_\_\_\_\_\_

For receiving appointment reminders, you prefer to be contacted by (check which applies best)

 Home Phone Call Cell Phone Call Text Reminder Email Reminder

Is this person currently a patient in our office? Yes No

Are there other family members involved in your child care/can receive information regarding dental care? □ Yes □ No

If yes, please give relationship and contact information:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_

Home Phone Number (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Cell Phone Number (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_

Home Phone Number (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_ Cell Phone Number (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full is expected at the end of each appointment.

 Cash Personal Check Credit Debit Card(Visa/Mastercard/Discover/AE)

**Insurance Information**

Named of Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_

Birthdate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Employment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Union or Local Number (if any) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

State \_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # \_\_\_\_\_\_\_\_\_\_\_\_\_ Policy ID # \_\_\_\_\_\_\_\_\_\_\_

Insurance Co. Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_

Zip Code \_\_\_\_\_\_\_\_\_

**Patient Medical History**

**Although dental personnel primarily treat the area in and around the mouth, your child's mouth is part of their entire body. Health problems that your child may have, or medications that he/she may be taking, could have an important interrelationship with the dentistry they receive. Thank you for answering the following questions.**

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Office Phone (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_

Date of Last Exam \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child under a physician's care currently? □ Y □ N

If yes, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Has your child been hospitalized for any surgical operation or serious illness in the last 5 years?

 □ Y □ N

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all current medications for your child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been told your child needs to premedicate prior to dental care? □Y □N

Does your child have any known allergies? □ Y □ N

If so please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Is your child on a special diet? □ Y □ N

Does your child have or has had any of the following?

 **Yes No**  **Yes No**

AIDS/HIV □ □ Blood Transfusion □ □

Alzheimer's Disease □ □ Breathing Problems □ □

Anaphylaxis □ □ Bruise Easily □ □

Anemia □ □ Cancer □ □

Angina □ □ Chemotherapy □ □

Artificial Heart Valve □ □ Low Blood Pressure □ □

Artificial Joint □ □ Lung Disease □ □

Asthma □ □ Mitral Valve Prolapse □ □

Blood Disease □ □ Pain in Jaw Joints □ □

Cortisone Therapy □ □ Parathyroid Disease □ □

Diabetes □ □Psychiatric Care □ □

Drug Addiction □ □ Radiation Treatments □ □

Easily Winded □ □ Recent Weight Loss □ □

Emphysema □ □ Renal Dialysis □ □

Epilepsy or Seizures □ □ Rheuamtic Fever □ □

Excessive Bleeding □ □ Rheumatism □ □ Excessive Thirst □ □ Scarlet Fever □ □

Fainting Spells/Dizziness □ □ Shingles □ □

Frequent Cough □ □ Sickle Cell Disease □ □

Frequent Diarrhea □ □ Sinus Trouble □ □

Frequent Headaches □ □ Spina Bifida □ □

Genital Herpes □ □ Stomach/Intestinal Disease □ □

Glaucoma □ □ Stroke □ □

Hay Fever □ □ Swelling of Limbs □ □

Heart Attack/Failure □ □ Thyroid Disease □ □

Heart Murmur □ □ Tonsilitis □ □

Heart Pace Maker □ □ Tuberculosis □ □

Heart Trouble/Disease □ □ Tumors or Growths □ □

Hemophilia □ □ Ulcers □ □

Hepatitis A □ □ Venereal Disease □ □

Hepatitis B or C □ □ Yellow Jaundice □ □

High Blood Pressure □ □

Hives or Rash □ □

Hypoglycemia □ □

Irregular Heartbeat □ □

Kidney Problems □ □

Leukemia □ □

**Patient Dental History**

How often does your child brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does your child floss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last dental check-up \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous dentist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any concerns for your child's teeth? □ Yes □ No

If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Yes No**

Is your child's water fluoridated? □ □

Does your child suck his/her thumb or fingers? □ □

Does your child grind or clench their teeth? □ □

Does your child currently take a fluoride supplement? □ □

**Authorization and Release**

Payment is due in full at the time of treatment unless prior arrangements have been approved.

This office participates out-of-network with insurance, and I understanding I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to this dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered to my insurance company.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in strictest confidence and it is my responsibility to inform the office of any changes to my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment, with my informed consent.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient (or parent/guardian if minor)