PEDIATRIC DENTAL SPECIALISTS

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We welcome you and your child to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for a lifetime.

TELL US ABOUT YOUR CHILD Today's Date: ____/____/_____

Child's Name:_____ Child's Birthdate: ____/____/_____ Child's Age: _____

Nickname:_____ Male Female

School: _____ Grade: _____ Child's Home #: (___)_____

Child's Home Address: _____

(Street) (City) (Zip Code)

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No Is child adopted? Yes No In foster home? Yes No

Whom may we thank for referring you? _____

Other siblings seen by our office: _____

Previous Dentist: _____ Phone #(___)_____ Last Visit Date: ____/____/_____

Parent's Marital Status Single Married Widowed Divorced Separated

PARENT'S INFORMATION

Mother Step Mother Guardian

Name: _____ Birthdate: ____/____/_____

Address: _____ E-Mail: _____

Work #: (___)_____ Ext: _____ Home #: (___)_____ Cell #: (___)_____

Employer: _____ Occupation: _____

SS #: _____ DL #: _____

Father Step Father Guardian

Name: _____ Birthdate: ____/____/_____

Address: _____ E-Mail: _____

Work #: (___)_____ Ext: _____ Home #: (___)_____ Cell #: (___)_____

Employer: _____ Occupation: _____

SS #: _____ DL #: _____

Neighbor or Relative not living with you:

Name: _____ Relation: _____ Phone #: (___)_____

Primary Dental Insurance

Insurance Co. Name: _____ Phone#: (___)_____

Policy Owner's Name: _____ Group: (Plan, Local, or Policy #): _____

Policy Owner's Birthdate: ____/____/_____ SS#: _____ Relationship to Patient: _____

Policy Owner's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____ Phone#: (___)_____

Policy Owner's Name: _____ Group: (Plan, Local, or Policy #): _____

Policy Owner's Birthdate: ____/____/_____ SS#: _____ Relationship to Patient: _____

Policy Owner's Employer: _____

Medical Information

Physician: _____ Phone#: (___)_____ Date of Last Exam: ____/____/_____

Has the child ever had any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Emotional Disorder	Y	N	Kidney / Liver Problems
Y	N	Hemophilia	Y	N	Autism/Asperger's	Y	N	Diabetes Type I / II
Y	N	Anemia	Y	N	ADD/ADHD	Y	N	Cancer*
Y	N	Sickle Cell Disease / Traits	Y	N	Epilepsy / Convulsions	Y	N	Handicaps / Disabilities*
Y	N	Blood Transfusion	Y	N	Eye Disorder	Y	N	Thyroid Condition*
Y	N	High Blood Pressure	Y	N	Speech Impairment	Y	N	Allergy Injections*
Y	N	Congenital Heart Defect	Y	N	Hearing Impairment	Y	N	Birth Defect*
Y	N	Heart Murmur	Y	N	Exposed to HIV but Neg	Y	N	Hospital Stays*
Y	N	Premed Needed	Y	N	HIV +/ AIDS	Y	N	Surgeries*
Y	N	Artificial Joints/Valves	Y	N	Hepatitis Type: _____			*Explain:___ _____
Y	N	Juvenile Arthritis	Y	N	Asthma			_____ _____
Y	N	Tuberculosis (TB)	Y	N	Seasonal Allergies			_____ _____
Y	N	Mononucleosis	Y	N	Skin Rash			_____ _____
Y	N	Chicken Pox	Y	N	Hives			_____ _____
Y	N	Measles	Y	N	Cleft Lip / Palate			_____ _____
Y	N	Rheumatic / Scarlet Fever	Y	N	Down Syndrome			_____

Please describe the child's current physical health: GOOD FAIR POOR

Are the child's immunizations current? Yes No If No, please explain:_____

Please list any known allergies (medicines, foods, latex, etc.)

_____

Please list all drugs and/or supplements that the child is currently taking:

_____

Please list any serious medical problems that the child has had:

_____

Patient's Dental History

Why did you bring the child to the dentist today? _____

Has the child ever had an unfavorable dental visit or serious/difficult issue with previous dental work*	Y	N
*Explain:		
Had an injury to the mouth?	Y	N
Has the child ever had any pain / tenderness in his / her jaw joint (TMJ/TMD)?	Y	N
Does the child brush his / her teeth daily?	Y	N
Floss his / her teeth daily?	Y	N
Does / did the child have any of the following:		
Suck Thumb / Finger / Lip / Objects If yes, how many months?_____ months **Past / Current**	Y	N
Use a pacifier? If yes, how many months?_____ months **Past / Current**	Y	N
Bite nails? If yes, how many months?_____ months **Past / Current**	Y	N
Breastfed? If yes, how many months?_____ months **Past / Current**	Y	N
Take a bottle at night? If yes, how many months?_____ months **Past / Current**	Y	N
Is the child's water fluoridated?	Y	N
Is the child taking fluoridated supplements?	Y	N
Home Water Supply Well City Bottled Filtered		

Parent/Guardian Initials: _____ Child's Name: _____ Date: ____/____/_____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

My method of payment will be: _____ Signature of parent/guardian: _____ Date: ____/____/_____

I certify that my child is covered by _____ Insurance Company and I assign directly to Pediatric Dental Specialists, PA all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent/guardian: _____ Date: ____/____/_____

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been approved.

I have received the Notice of Privacy Practices. Signature: _____ Date: ____/____/_____

Responsible Party

Pediatric Dental Specialists, PA understands there are times a parent or guardian is unable to bring a child in for scheduled appointments or emergencies. As we require parental authorization to care for your child, we ask that you list any family members or other persons of at least 18 years of age, who may be informed or participate in your child's care. Appropriate identification in the form of picture ID will be required from the accompanying adult in the absence of a parent.

Name: _____ Relationship _____ Phone #: (___)_____

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Name: _____ Relationship _____ Phone #: (___)_____

Name: _____ Relationship _____ Phone #: (___)_____

Name: _____ Relationship _____ Phone #: (___)_____

By signing, I acknowledge that the above named parties are allowed to bring my child to appointments, have the power to consent to treatment changes at those appointments, are at least 18 years of age, and will be held responsible for any estimated co-payments at the time the service is performed.

Patient Name: _____

Parent/Guardian Signature: _____ Date: ____/____/_____

Witness: _____ Date: ____/____/_____

Parent/Guardian Initials: _____ Child's Name: _____ Date: ____/____/_____