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Board Certified Pediatric Dentist

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Diplomate of... AMERICAN BOARD OF PEDIATRIC DENTISTRY

Welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with your child.

Patient Information

Child's Name _____ Soc. Sec. # _____
Last Name First Name Initial

Parents Name _____ Soc. Sec. #_____
Last Name (if different from child) First Name Initial

Address _____

City _____ State _____ Zip _____ Phone _____

Sex: ☐M ☐F Age_____ Birthdate_____ School_____

Grade_____ Hobbies / Sports _____

Parent's e-mail _____ Whom may we thank for referring you? _____

Notify in case of emergency_____ Home Phone_____ Work Phone_____

Parent Information #1

Person responsible for account _____
Last Name First Name Initial

Relation to Child_____ Birthdate_____ Soc. Sec. # _____

Address *(if different from child)* _____Home Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation_____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan _____

Parent Information #2

Person responsible for account _____
Last Name First Name Initial

Relation to Child_____ Birthdate_____ Soc. Sec. # _____

Address *(if different from child)* _____Home Phone _____

City _____ State _____ Zip _____

Person Responsible Employed by _____ Occupation_____

Business Address _____ Business Phone _____

Insurance Company _____ Phone _____

Contract #_____ Group #_____ Subscriber #_____

Name of other dependents under this plan _____

Please complete both sides

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Patient Medical History Form

Child's Name: _____ Date of Birth: _____ Age: _____ Date: _____

Address: _____ Telephone: (_____) _____

Physician's name (Medical Doctors): _____ Telephone: (_____) _____

Please Circle the Appropriate Answer

1. Does your child have a health problem? ..... YES NO
2. Was your child a patient in a hospital? ..... YES NO
3. Date of last physical exam: _____
4. Is your child now under medical care? ..... YES NO
5. Is your child taking medication now? ..... YES NO
   If so, for what? _____
6. Has your child ever had a serious illness or operation? .... YES NO
   If so, explain: _____
7. Does your child have (or ever had) any of the following diseases?
   a. Rheumatic fever or Rheumatic heart disease? ..... YES NO
   b. Congenital heart disease? ..... YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke) ..... YES NO
   d. Allergy? Food _____ Medicine _____ YES NO
      Other _____ YES NO
   e. Asthma ☐ Hay Fever ☐ ..... YES NO
   f. ADD ☐ ADHD ☐ ..... YES NO
   g. Hives or skin rash ..... YES NO
   h. Fainting spells or seizures ..... YES NO
   i. Hepatitis, jaundice or liver disease ..... YES NO
   j. Diabetes ..... YES NO
   k. Inflammatory rheumatism (painful or swollen joints) ... YES NO
   l. Arthritis ..... YES NO
   m. Stomach Ulcers ..... YES NO
   n. Kidney trouble ..... YES NO
   o. Tuberculosis (TB) ..... YES NO
   p. Persistent cough or cough up blood ..... YES NO
   q. Venereal disease ..... YES NO
   r. Epilepsy ..... YES NO
   s. Sickle Cell disease ..... YES NO
   t. Thyroid disease ..... YES NO
   u. AIDS ..... YES NO
   v. Emphysema ..... YES NO
   w. Psychiatric treatment ..... YES NO
   x. Cleft lip / palate ..... YES NO
   y. Cerebral palsy ..... YES NO
   z. Mental retardation ..... YES NO
   aa. Hearing disability ..... YES NO
   bb. Developmental disability ..... YES NO
      If yes, explain: _____
   cc. Was your child premature? ..... YES NO
      If yes, how many weeks _____
   dd. Other _____
8. Does your child have to urinate (pass water) More than six times a day? ..... YES NO
9. Is your child thirty most of the time? ..... YES NO
10. Has your child had abnormal bleeding associated with previous surgery, extractions or accidents? ..... YES NO
11. Does he/she bruise easily? ..... YES NO
12. Has he/she ever required a blood transfusion? ..... YES NO
13. Does he/she have any blood disorders such as anemia, etc ..... YES NO
14. Has he/she ever had surgery, x-ray or chemotherapy? for a tumor, growth, or other condition? ..... YES NO
15. Does your child have a disability that prevents treatment in a dental office? ..... YES NO
16. Is he/she taking any of the following?
   A. Antibiotics or sulfa drugs ..... YES NO
   B. Anticoagulants (blood thinners) ..... YES NO
   C. Medicine for high blood pressure ..... YES NO
   D. Cortisone or steroids ..... YES NO
   E. Tranquilizers ..... YES NO
   F. Aspirin ..... YES NO
   G. Diatom or other anticonvulsant ..... YES NO
   H. Insulin, Tolbutamide, Orinase, or similar drug ..... YES NO
   I. Any Other? ..... YES NO
17. Is he/she allergic to, or has he/she ever reacted adversely to any of the following? ..... YES NO
   A. Local anesthetics ..... YES NO
   B. Penicillin or other antibiotics ..... YES NO
   C. Sulfa drugs ..... YES NO
   D. Barbiturates, sedatives or sleeping pills ..... YES NO
   E. Aspirin ..... YES NO
   F. Any other? ..... YES NO
18. Has he/she any serious trouble associated with any previous dental treatment? ..... YES NO
   If so, explain: _____
19. Has your child been in any situation which could expose him/her to x-rays or other ionizing radiators? ..... YES NO
20. Last date of dental examination: _____
21. Has he/she ever had orthodontic treatment (worn braces) .. YES NO
22. Has he/she ever been treated for any gum diseases (Gingivitis, periodontitis, trenchmouth, pyorrhea? ..... YES NO
23. Does his/her gums bleed when brushing teeth? ..... YES NO
24. Does he/she grind or clench teeth? ..... YES NO
25. Has he/she often have toothaches? ..... YES NO
26. Has he/she had frequent sores in his/her mouth? ..... YES NO
27. Has he/she had any injuries to is/her mouth or jaws? ..... YES NO
   If yes, explain: _____
28. Does he/she have any sores or swellings of his/her mouth or jaws? ..... YES NO
28. Have you been satisfied with your child's previous dental care? ..... YES NO

CONSENT: The undersigned hereby authorizes Doctor to take x-rays, study models, photographs, or any diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patients dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose an employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for my dependents is mine, due an payable at the time services are rendered unless financial arrangements have been made. I further understand that a **1-1/2% Service Charge (18% Annually)** will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the Indebtedness, together with such collection cost and reasonable attorney fees as may be required to effect collection on this note.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship to Patient _____