Pediatric Dentistry

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and Associates
Pediatric Dentistry

PATIENT INFORMATION

Child's Name ____________________ Nickname ____________________ Sex: M / F
Birthday ____________________ Age ____
Reason for visit: ______ Check-up & Full Mouth Care ______ Pain, Discomfort, Emergency

PATIENT / GUARDIAN HISTORY

Residence Address ____________________ City ____________________ Zip Code ______
Home Phone ____________________ Email address ____________________
Cell Phone - Mother ____________________ Cell Phone - Father ____________________

Father's Name ____________________ Occupation ____________________ D.O.B. ________
Married___ Single___ Divorced___ Widowed___ SS# ____________________
Employed by ____________________ Bus Phone ____________________

Mother's Name ____________________ Occupation ____________________ D.O.B. ________
Married___ Single___ Divorced___ Widowed___ SS# ____________________
Employed by ____________________ Bus Phone ____________________

Please list names of child's siblings and their ages ____________________
Who referred you, or how did you find our office? ____________________
Name of dental insurance, if any ____________________
Insurance Address ____________________ Group/Policy # ____________________

CHILD'S HEALTH HISTORY

Describe your child's overall physical health: (circle one) Excellent / Fair / Poor

1. Is your child currently under the care of a physician? Y / N
   If so, please describe ____________________
2. Has your child had any serious illness or injury? Y / N
   If so, please describe (include age) ____________________
3. Is your child current on all vaccinations? Y / N
4. Is there any unusual dental history, such as accidents to teeth or a family member with missing or extra teeth? Y / N
   Explain ____________________
5. Does your child have any habits such as thumb sucking, nail biting lip or cheek biting? Y / N
6. Has your child experienced any unfavorable reaction to medicine such as penicillin, aspirin or local anesthetic? Y / N
7. Is your child taking any drugs or medication regularly? Y / N
   If so, please list ____________________
8. Has your child ever had or currently have any of the following:

Sensory Sensitivity	Y / N	Diabetes	Y / N	Epilepsy/Seizures	Y / N	Kidney Problems	Y / N
Heart Defect/Surgery	Y / N	Asthma	Y / N	Liver Problem	Y / N	Hearing Impairment	Y / N
Severe Food Allergy	Y / N	Autism	Y / N	HIV/AIDS	Y / N	Hearing Aid/Implant	Y / N
Developmental Delay	Y / N	Cancer	Y / N	Abnormal Bleeding	Y / N	Blood Transfusion	Y / N
Rheumatic Fever	Y / N	Hepatitis	Y / N	Heart Murmur	Y / N	ADD/ADHD	Y / N
Learning Disability	Y / N	Cerebral Palsy	Y / N	Tuberculosis	Y / N	Mental Illness	Y / N
Down Syndrome	Y / N			Vision Impairment	Y / N		

Office Policy: The fees for examination and/or emergency treatment must be paid when service is rendered. All deductibles, co-payments and portions of the bill that insurance does not cover are due at the time of service. A late fee of 1.5% per month will be charged to any balance exceeding 90 days.

Signature ____________________ Relationship to Patient ____________________ Date ________
Person financially responsible for child's account ____________________