## DENTAL HISTORY

Why did you bring your child to the dentist today?

_____

- Has your child ever had dental problems or previous dental treatment? YES NO
- Has your child ever had any pain/tenderness in their jaw (TMJ/TMD)? YES NO
- Does your child brush daily? YES NO
- Floss their teeth daily? YES NO
- Does your child have any of the following habits?
  - Finger/Pacifier habit YES NO
  - Bottle/sippy cup habits YES NO
  - Breast Feeding YES NO
  - Lip Sucking/biting YES NO
  - Nail biting YES NO

**Emergency Contact Name & Telephone Number**

_____

_____

Relationship to patient _____

## MEDICAL HISTORY

Has your child had problems with any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Y | N | Allergies | Y | N | Cancer |
| Y | N | Latex Allergy | Y | N | Kidney |
| Y | N | Asthma/RAD | Y | N | Hepatitis /Liver |
| Y | N | Heart Murmur/Defect | Y | N | HIV+/AIDS |
| Y | N | Diabetes | Y | N | GERD |
| Y | N | Developmental Disability | Y | N | Anorexia/Bulimia |
| Y | N | Autism/ASD | Y | N | Hearing Impairment |
| Y | N | ADD/ADHD | Y | N | Shunts/Implants |
| Y | N | Seizures/Epilepsy | | | |
| Y | N | Bleeding Disorder | | | |
| Y | N | Operations/Hospitalizations_____ | | | |
| Y | N | Syndrome _____ | | | |
| Y | N | Other_____ | | | |

*Please discuss those things marked yes, as well as any other serious medical problems your child has had

_____

_____

Please list all prescription and over the counter medications your child is *currently taking* and for what condition

_____

Please list all drugs your child is *allergic* to and type of reaction _____

_____

Child's Physician _____ Phone # _____ Date of last visit _____

Is your child currently under the care of a physician? YES NO

Your child's current physical health is GOOD FAIR POOR

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

I acknowledge the information that I have given is complete and correct to the best of my knowledge, it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature _____Relationship to child _____Date _____

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you have any questions, please feel free to ask us at any time.

**OFFICE USE ONLY**

I have verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials _____ Date _____Doctors Comments_____

# PEDIATRIC DENTAL SPECIALISTS, P.C.

## *Welcome!*

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

## ABOUT YOUR CHILD

Today's Date _____

Name _____
FIRST MI LAST

Sex: M F Age: _____ Birthdate _____/_____/_____

Address _____
APT/CONDO#

_____
CITY STATE ZIP

Primary phone # _____

Family Email _____

## MORE ABOUT YOUR CHILD

Do you have legal custody of this child? Yes No

Is your child adopted? Yes No

Who may we thank for referring you to our office?

_____

Previous Dentist _____

Previous Dentist Phone # _____

Date of Last Visit _____

Other family members seen by us? _____

_____

## PRIMARY DENTAL INSURANCE

Ins Co. Name _____

Ins. Co. Phone # _____

Group # (Plan, Local or Policy #)_____

Member ID # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate _____/_____/_____

Insured's Employer _____

I authorize my insurance company to pay directly to dentist

Signature _____

## ACCOUNT INFORMATION

Parent's Name _____
FIRST MI LAST

Parent's SS# _____

Work # _____ Ext. ____ Home # _____

Cell # _____ D.L. # _____

Employer _____

Occupation _____

Parent's Name _____
FIRST MI LAST

Parent's SS#_____

Work #_____Ext_____Home # _____

Cell # _____D.L. #_____

Employer _____

Occupation _____

Marital Status: Married Single Divorced Separated Other

## OTHER

Person Responsible for Account

Name _____Relationship to child _____

Billing address if different from child's

_____
ADDRESS APT/CONDO#

_____
CITY STATE ZIP

Primary Phone #_____ Wk #_____

## SECONDARY DENTAL INSURANCE

Ins. Co. Name _____

Ins. Co. Phone # _____

Group # (Plan, Local or Policy#) _____

Member ID # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate _____/_____/_____

Insured's Employer _____

I authorize my insurance company to pay directly to the dentist

Signature _____