DENTAL HISTORY

(Please explain briefly all YES answers.)

Child's Name _____ Date _____

Date of last visit to a dentist _____ Name of former dentist _____

Address (city/state/zip) _____

For what service? _____

	Yes	No
Has child complained about dental problems? _____	☐	☐
Any unhappy dental experiences? _____	☐	☐
Any injuries to mouth/teeth/head? _____	☐	☐
Any mouth habits? (thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc.) _____	☐	☐
Any unusual speech habits? _____	☐	☐

	Yes	No
Orthodontic appliances worn now or in the past? _____	☐	☐
Do you assist child with tooth brushing? _____	☐	☐
Is fluoride taken in any form? _____	☐	☐

Fluoride Toothpaste ☐ Fluoride Mouthwash ☐ Fluoridated Water ☐ Fluoride Tables/Drops ☐

Child's attitude toward dentistry _____

Additional Comments _____

HEALTH HISTORY

Child's Physician _____ Phone _____

Address(city/state/zip) _____

Approximate date of last physical examination _____ Results _____

	Yes	No
Is child receiving any medication or drugs? _____	☐	☐
Is there any excessive bleeding when cut? _____	☐	☐
Has child ever been hospitalized? _____	☐	☐
Is there any allergy to penicillin or other drugs? _____	☐	☐
Are there other allergies? (food-pollen-animals-dust-other)	☐	☐
Does child have a chronic cough? _____	☐	☐
Has the child been exposed to a friend or relative with Tuberculosis? _____	☐	☐
Does child have difficulty in school? _____	☐	☐

	Yes	No
Does child have good physical coordination? _____	☐	☐
Are there emotional problems? _____	☐	☐

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that we have not discussed: _____

Date Reviewed: _____ Name of Reviewer _____

Date Reviewed: _____ Name of Reviewer _____

Date Reviewed: _____ Name of Reviewer _____

Has child had any history of or difficulty with any of the following: (check all that apply)

☐ Anemia	☐ Chicken Pox	☐ Rheumatic Fever	☐ Kidney	☐ Thyroid	☐ Lungs
☐ Asthma	☐ Chronic Sinus	☐ Heart	☐ Liver	☐ Tuberculosis	☐ Blood
☐ Arthritis	☐ Convulsions	☐ Heart Murmur	☐ Malignancies	☐ Ulcers	☐ Syndromes
☐ Bladder	☐ Diabetes	☐ Hepatitis	☐ Measles	☐ Digestive	☐ Brain
☐ Blood Transfusion	☐ Epilepsy	☐ HIV Infection	☐ Mumps	☐ Skin	☐ Nervous System
☐ Cerebral Palsy	☐ Fainting	☐ Immune Deficiency	☐ Hearing	☐ Muscle	

Get-Acquainted Questionnaire

(Please print complete answers)

Swanson Pediatric Dental Center

Randel P. Swanson, D.D.S., Pharm.D.

Child's Name _____ Nickname _____
Last First Middle

Age _____ Birth date _____ Male ☐ Female ☐ School/Grade _____

Father's Name _____ Date of Birth _____
Last First Middle

Mother's Name _____ Date of Birth _____
Last First Middle

Home Address _____ How Long? _____
Street City Zip Code

Home Phone _____ Mom's cell _____ Dad's cell _____

If parents can't be reached, friend or relative not living in the same house to notify should an emergency arise:

Name _____ Relationship _____ Phone _____

Does your child live with Mom, Dad, both parents, or other? _____

Names and ages of other children in the family: Check here if seen at this office

Name _____ Age _____ ☐
Name _____ Age _____ ☐
Name _____ Age _____ ☐

Father's Occupation _____ Work phone _____ How long with present job? _____
Name of Employer _____ City _____
Mother's Occupation _____ Work phone _____ How long with present job? _____
Name of Employer _____ City _____
Person responsible for this account: Name _____
Address (city/state/zip) _____
Does child live with person responsible for the account? Yes ☐ No ☐

INSURANCE

Is child covered by DSHS? Yes ☐ No ☐ Is child covered by dental insurance? Yes ☐ No ☐

PRIMARY DENTAL INSURANCE CARRIER:

Insurance Company _____ Address _____
Employee covered by this plan _____ Social Security No. _____
Birth date _____ Group No. _____ Union or Local No. _____
Name of Union _____ Has patient had previous dental care under this program? Yes ☐ No ☐

SECONDARY DENTAL INSURANCE CARRIER:

Insurance Company _____ Address _____
Employee covered by this plan _____ Social Security No. _____
Birth date _____ Group No. _____ Union or Local No. _____
Name of Union _____ Has patient had previous dental care under this program? Yes ☐ No ☐

Who may we thank for referring you to our office? _____
Address (city/state/zip) _____

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I also agree to the use of anesthetics and premedications considered necessary or advisable by the dentist for the comfort and well being of the child. I accept full financial responsibility for my child's account regardless of my ability to be reimbursed by an insurance company, ex-spouse, or any other third party.

Parent or Legal Guardian _____ Date _____
Signature

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Parent or Legal Guardian _____

Patient's Name_____

OFFICE POLICIES

APPOINTMENTS

Parents are welcome to accompany their child throughout the dental visit. However, some children cooperate better when parents wait in the reception area during dental procedures. If your child is scheduled for a restorative appointment, only one parent at a time will be able to come back. So that Dr. Swanson can give his full attention to your child during a restorative procedure, we ask that other children with you please wait in the waiting area with an adult supervising them. Thank you for your cooperation!

PAYMENT OPTIONS AND INSURANCE

Payment for fees if you do not have insurance is due at the time of treatment. If your child is scheduled for an oral sedation or nitrous oxide, we do expect payment for that the day of the appointment since insurance doesn't usually cover it. If your child has an appointment scheduled for treatment, we will ask for your patient portion the day of the appointment. We are sensitive to the fact that some parents may not be able to pay cash for their child's treatment. We accept Visa or MasterCard. If there is a dispute with your insurance company, we will assist you in resolving the problem. However, responsibility for resolving the dispute remains with you, the subscriber. If there is an outstanding account balance, it will need to be paid in full before more treatment is done. Payments on accounts need to be paid in full in a timely manner. If not, at our discretion, we may send a letter dismissing your family from our practice.

CANCELLATIONS/NO SHOWS

Please call at least 48 hours in advance if you are unable to keep your child's appointment. It will be considered a No Show appointment if you call us without giving at least 24 hours notice. (A Thursday cancellation after 5pm before a Monday appointment at 8:00am is considered 24 hours since we're not open on Fridays.) Also, it will be considered a No Show appointment if you are 15 minutes late to your appointment. If your child is sick, please call as soon as possible, even after hours. Our office will call to confirm your appointment the day before. If we cannot confirm your appointment with a person or an answering machine, it might be cancelled. However, it is still your responsibility to keep your appointment. Our office has the following NO SHOW policy:

First No Show: If you have insurance or are paying privately, a no show charge of 50.00 for a missed exam appointment will be charged as well as 100.00 for a missed restorative appointment.

Second No Show: If you have insurance or are paying privately, a letter may be sent dismissing your family from our practice, or at our discretion, we may reschedule you after you pay the no show charge for a missed appointment.

Our goal is to provide good dental care for your children at a reasonable cost. Your cooperation in keeping your scheduled appointments will help us achieve that goal. Thank you!

SIGNATURE

I have read the above policies and have had any questions answered. I authorize Dr. Randel Swanson's office to release to my insurance company any information from my child's dental records relating to an insurance claim. I hereby authorize payment directly to Dr. Swanson for the group insurance benefits otherwise payable directly to me. I also authorize Dr. Swanson's office to release my records, including treatment, x-rays and account information to other dental offices if needed for a shared patient. I accept full responsibility for my child's account regardless of my ability to be reimbursed by an insurance company, ex-spouse, or any other third party.

_____ _____

Signature of Parent or Guardian Date

First Visit

I hereby authorize Dr. Randel P. Swanson and his assistants to perform upon my child dental treatment that is beneficial for my child's health. This may include a cleaning, x-rays, fluoride treatment and an exam.

Parent or Guardian's Signature_____ Date_____