pediatric dental specialists®

Child's Name_____ Gender (circle one): Male Female

Nickname_____ Birthday ____/_____/_____

How did you hear about our office? _____

MEDICAL HISTORY

Child's Pediatrician _____Telephone ( ) _____

	YES	NO
1. Has your child ever seen a physician other than their pediatrician? Please List: _____	___	___
2. Was your child premature? How many weeks? _____	___	___
3. Is your child currently taking any medications daily? Please List: _____	___	___
4. Has your child ever been hospitalized or had surgery? Please List: _____	___	___
5. Is your child allergic to any food, medications, latex, etc? Please List: _____	___	___
6. Does your child require antibiotic premedication before dental visits?	___	___

Has your child had a history of the following? (Check any that apply)

___Anemia	___Asthma or Hay Fever	___AIDS/HIV
___Cancer	___Behavioral/Learning Problems	___Cerebral Palsy
___Heart Murmur/MVP	___Developmentally Delayed	___Hepatitis
___Diabetes	___Congenital Birth Defects	___Seizures
___Respiratory Problems	___Liver Problems	___Mouth Breathing/ Snoring
___Rheumatic Fever	___Severe or difficulty breathing	___Hearing Loss
___Speech Impairment	___Stomach Ulcers	

Other: _____

DENTAL HISTORY

	YES	NO
1. Is this your child's first visit to a dentist? Who was your child's previous dentist? _____	___	___
2. Does your child go to bed with juice or milk?	___	___
3. Does your child suck their thumb/finger or use a pacifier?	___	___
4. Does your child receive fluoride supplements?	___	___

5. How do you feel your child will react to the dentist? _____
6. How often does your child brush his/her teeth? _____
7. Do you have any concerns about your child's teeth? _____

PATIENT INFORMATION

Mailing Address City State Zip Code

_____

Home Phone Number **Email address**

_____

Guardian (1) Full Name Relationship to patient SSN (Required unless 100%paid on date of service)

_____

Cell phone Occupation

_____

Guardian (2) Full Name Relationship to patient SSN (Required unless 100%paid on date of service)

_____

Cell phone Occupation

_____

DENTAL INSURANCE INFORMATION (RESPONSIBLE PARTY)

Name of Insured_____ Birth date____/____/_____

Name of Employer_____ Insurance Company_____

Insurance Company Address_____City_____State_____Zip_____

**Member ID_____

**Group/Policy#_____

HIPAA PRIVACY AND FINANCIAL RESPONSIBILITY AGKNOWLEDGEMENT

Please initial the following: Initial

I have read and understand the Hipaa Notice of Privacy Practices given to me: _____

I have read and understand the Financial Policy given to me: _____

Payment is expected on the date of service. The permission of the parent or guardian is necessary for dental treatment of a minor. I hereby give the doctors permission to use such measures necessary in the professional judgment to render the best dental treatment for my child. I also give my permission for photographs for diagnosis, treatment planning, and teaching to be made. I certify that this information is true and correct to the best of my knowledge. I will notify you of changes in my child's health status or the above information. I understand that insurance claims are filed electronically. This is acceptable to me.

MISSED APPOINTMENT POLICY

If for any reason you need cancel or change an appointment, it is important that you give our office at least a 24 hour notice, otherwise it will be considered a missed appointment. We reserve the right after missed appointments to request pre-payment prior to rescheduling. Two or more missed appointments will result in dismissal from our practice.

---I have read the policies above. I understand and agree to abide by the listed terms.---

Signature_____ Relationship to Child_____ Date_____