Pediatric Dental
ASSOCIATES

To help us better serve you, please complete the following form to the best of your ability.
If you have questions, do not hesitate to let us know. Thank you for choosing our office!

Child's Name: _____ **DOB (MM/DD/YY):** _____

Nickname: _____ **Age:** _____ **Child's Social Security Number:** _____

Gender: ☐ Male ☐ Female ☐ Other

Home Address: _____

City, State, Zip: _____ **Phone Number:** _____

Email (parent/guardian's): _____

School: _____ **Grade:** _____ **Reason for Visit:** _____

Who can we thank for referring you to us? (Please check all that apply.)

☐ Primary Care Doctor _____ ☐ Friend/Family _____

☐ General Dentist _____ ☐ School/Daycare _____

MEDICAL HISTORY

Child's Physician: _____ **City:** _____ **Date Last Seen:** _____

Is your child presently under the care of a physician for any medical issue? ☐ Yes ☐ No

If yes, please describe: _____

Is your child currently taking medication? ☐ Yes ☐ No

If yes, please describe: _____

Has your child ever been hospitalized for surgery? ☐ Yes ☐ No

If yes, please describe: _____

Does your child have allergies to any food or medication? ☐ Yes ☐ No

If yes, please describe: _____

Is your child pregnant? ☐ Yes ☐ No

Pediatric Dental ASSOCIATES

Does your child have a history of:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Heart Murmurs	☐	☐	Premature Birth	☐	☐	Artificial Prosthesis	☐	☐	Cancer/Tumors
☐	☐	Heart Trouble	☐	☐	Hearing Problems	☐	☐	Congenial Birth Defects	☐	☐	Chemo/Radiation Therapy
☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐	Speech Problem	☐	☐	Leukemia
☐	☐	Allergies	☐	☐	Asthma	☐	☐	Anemia	☐	☐	Hepatitis
☐	☐	Allergy or Sensitivity to Anesthesia	☐	☐	Epilepsy	☐	☐	ADD/ADHD	☐	☐	Bleeding Problems
☐	☐	Drug Sensitivities	☐	☐	Seizures/Convulsions	☐	☐	Autism/Asperger's	☐	☐	Blood Disorders
☐	☐	High Temperature	☐	☐	Recurrent Headaches	☐	☐	AIDS/ARC/HIV	☐	☐	High Blood Pressure
☐	☐	Brian Injury/Concussion	☐	☐	Fractured Jaw	☐	☐	Kidney/Liver Involvement	☐	☐	History of Blood Transfusion
☐	☐	Vision Problems	☐	☐	Lung Problems	☐	☐	Nervous System Issues	If yes, date of transfusion: _____		

Is there anything else regarding your child's physical, mental, or emotional health you feel we should know? ☐ Yes ☐ No

If yes, please describe: _____

DENTAL HISTORY

Is this your child's first visit to a dentist? ☐ Yes ☐ No

Previous Dentist: _____ **City:** _____ **Date Last Seen:** _____

Date Last X-rays: _____

Any injury to your child's teeth or jaws? (Falls, blows, chips, etc.) ☐ Yes ☐ No

Does your child have a history of: (Please check all that apply.)

☐ Thumb sucking ☐ Lip sucking ☐ Pacifier

☐ Finger sucking ☐ Nail biting

Has your child experienced any unfavorable reaction from previous medical or dental care? ☐ Yes ☐ No

If yes, please describe: _____

How do you think your child will act towards the dentist? _____

Age of child when discontinued bottle or nursing: _____

Name of Family Dentist: _____ **City:** _____

Pediatric Dental ASSOCIATES

PREVENTATIVE DENTAL HISTORY

How often does your child brush? _____ **Is toothbrushing supervised?** ☐ Yes ☐ No

If yes, by whom and when? _____

Is dental floss used? ☐ Yes ☐ No

Does your child receive: ☐ Fluoride in Vitamins ☐ Fluoride Tablets/Drops ☐ Fluoridated Water ☐ None

If yes, how often? _____

CHILD'S INSURANCE INFORMATION

Child's Insurance Carrier _____ **Child's Insurance ID Number (if applicable):** _____

FAMILY INFORMATION AND FINANCIAL RESPONSIBILITY

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION

Name: _____ **Relationship:** _____

DOB: _____ **Social Security Number:** _____ **Email Address:** _____

Home Address (if differentthan child): _____

City, State, Zip: _____ **Phone Number:** _____

Occupation: _____ **Employed By:** _____

Business Address: _____

City, State, Zip: _____ **Business Phone Number:** _____

Insurance Company: _____ **Group Number:** _____ **Subscriber's ID Number:** _____

Is your child eligible for state/county aid? ☐ Yes ☐ No

Names and ages of child's siblings (if applicable): _____

_____

Has any member of the family been a patient in this office before? ☐ Yes ☐ No

If yes, patient's name: _____

Pediatric Dental
ASSOCIATES

Name, address, and phone number of closest relative or friend:

Name: _____

City, State, Zip: _____ **Phone Number:** _____

If the family is not living together, the parent/guardian bringing the child in is responsible for the child's account.

AUTHORIZATION

I hereby attest, that I am the legal, responsible parent or guardian of the aforementioned child and I hereby agree that I have read the above questions and have filled them out to the best of my ability. I hereby consent to such examinations, diagnostic, preventative, and curative treatment, x-rays, local anesthesia, inhalation and oral medication as is necessary upon _____. If I have any objections to certain aspects of treatment, I have stated so in the space provided below. I will assume responsibility for fees associated with those procedures for my child.

Signature: _____

Relationship to child: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

PLEASE NOTE: PAYMENT IS EXPECTED FOR SERVICE(S) RENDERED AT THE TIME OF FIRST VISIT. FINANCIAL ARRANGEMENTS FOR SUBSEQUENT TREATMENT MAY BE MADE FOLLOWING THE DIAGNOSIS. THANK YOU.

A CHARGE MAY BE MADE FOR BROKEN APPOINTMENTS UNLESS THE OFFICE IS NOTIFIED 24 HOURS BEFORE APPOINTMENT.