Pediatric Dental Specialists & Northwest Orthodontics

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CHILD'S NAME ______________________ DATE OF BIRTH __________

PREFERRED NAME ______________________ MALE / FEMALE __________

CHILD'S PHYSICIAN ______________________ PHONE # __________

FAMILY DENTIST ______________________ PHONE # __________

IS YOUR CHILD IN GOOD GENERAL HEALTH? YES ______ NO ______

IS YOUR CHILD SEEN ROUTINELY BY A PHYSICIAN? YES ______ NO ______

IF YES, WHY? ______________________

____

NAME OF PERSON WHO REFERRED YOU TO OUR OFFICE: ______________________

CIRCLE ONE: Dentist Physician Friend Internet Phonebook Other

HAS YOUR CHILD HAD ANY HISTORY OF:	YES	NO
seizures	____	____
blood disorder	____	____
cerebral palsy	____	____
heart trouble	____	____
rheumatic fever	____	____
allergies	____	____
diabetes	____	____
asthma	____	____
kidney disorders	____	____
liver disorders	____	____
developmental delays or disorders	____	____
recurring ear infections	____	____
other, please describe	______________	

IS YOUR CHILD TAKING MEDICINE? IF YES, FOR WHAT? ______________________

HAS YOUR CHILD EVER BEEN HOSPITALIZED? IF YES, WHEN AND FOR WHAT? ______________________

____

HAS YOUR CHILD HAD ANY UNFAVORABLE REACTIONS OR ALLERGY TO DRUGS, INCLUDING ANTIBIOTICS (penicillin) & LOCAL ANESTHETIC SOLUTION? YES______ NO______

If yes, please indicate medication and reaction ______________________

IS YOUR CHILD CURRENTLY:	YES	NO
finger or thumbsucking	____	____
breast or bottle feeding	____	____
using a pacifier	____	____
snoring	____	____
grinding teeth	____	____

CHIEF PURPOSE OF THIS DENTAL VISIT ______________________

IS YOUR CHILD IN PAIN NOW? ______________________

HAS YOUR CHILD HAD ANY PREVIOUS DENTAL TREATMENT? ______________________

HAS YOUR CHILD HAD ANY UNFAVORABLE DENTAL OR MEDICAL EXPERIENCE? ______________________

IF YES, PLEASE EXPLAIN ______________________

____

CHILD RESIDES WITH WHICH PARENT: ☐ BOTH ☐ MOM ☐ DAD ☐ OTHER

HOME ADDRESS ____________________

CITY __________ STATE ______ ZIP __________ CHILD'S SCHOOL ____________________

HOME PHONE # __________ MOM'S CELL # __________ DAD'S CELL # __________

MOM'S WORK # __________ DAD'S WORK# __________

EMERGENCY PHONE # OF FRIEND OR RELATIVE

NAME ____________________ PHONE # __________

PLEASE BE AWARE THAT THE PARENT BRINGING THE CHILD FOR DENTAL CARE IS LEGALLY RESPONSIBLE FOR PAYMENT OF ALL FEES.

FATHER'S / GUARDIAN NAME ____________________

S.S. # __________ TEXAS DRIVER'S LICENSE # __________

FATHER'S / GUARDIAN EMPLOYER ____________________ YRS. WITH FIRM __________

OCCUPATION ____________________

EMPLOYER ADDRESS ____________________

MOTHER'S / GUARDIAN NAME ____________________

S.S. # __________ TEXAS DRIVER'S LICENSE # __________

MOTHER'S / GUARDIAN EMPLOYER ____________________ YRS. WITH FIRM __________

OCCUPATION ____________________

EMPLOYER ADDRESS ____________________

PARENTS' ADDRESS IF DIFFERENT FROM CHILD: MOM __________ DAD __________

STREET ____________________ CITY __________ ZIP __________

DO YOU CARRY DENTAL INSURANCE? ☐ YES ☐ NO
Policyholder is: ☐ DAD ☐ MOM ☐ OTHER

LIST SIBLINGS **SEEN** IN OUR PRACTICE

__________ __________ __________

PARENT'S SIGNATURE ____________________ **DATE** __________

RELATIONSHIP IF OTHER THAN PARENT SIGNING ____________________

IT IS OUR OFFICE POLICY TO BILL YOUR INSURANCE CARRIER AS A COURTESY TO YOU. YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR ACCOUNT IN ANY EVENT THAT THE INSURANCE COMPANY DOES NOT PAY THE BALANCE WITHIN 60 DAYS.