PEDIATRIC DENTAL SPECIALISTS
& ORTHODONTICS

CHILD'S **LEGAL** NAME _____ DATE OF BIRTH _____

PREFERRED NAME _____ MALE/FEMALE _____

CHILD'S PHYSICIAN _____ FAMILY DENTIST _____

HOW DID YOU HEAR ABOUT OUR OFFICE: (CIRCLE ONE)

Dentist Physician Friend Internet 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	_____	_____
recurring ear infections	_____	_____
developmental, emotional, or behavioral concerns	_____	_____
speech or learning difficulties	_____	_____
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 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 thumb sucking	_____	_____
breast or bottle feeding	_____	_____
using a pacifier	_____	_____
snoring	_____	_____
grinding teeth	_____	_____

PURPOSE OF THIS DENTAL VISIT

_____

IS YOUR CHILD IN PAIN NOW?

_____

HAS YOUR CHILD HAD ANY UNFAVORABLE DENTAL OR MEDICAL EXPERIENCES_____

_____

IF YES, PLEASE EXPLAIN _____

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ANY SIBLINGS ALREADY WITH OUR PRACTICE? ☐ YES ☐ NO

NAMES: _____

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 # _____

PREFERRED EMAIL CONTACT

_____

FATHER'S/GUARDIAN NAME: _____

FATHER'S OCCUPATION AND EMPLOYER: _____

MOTHER'S/GUARDIAN NAME: _____

MOTHER'S OCCUPATION AND EMPLOYER: _____

IS PATIENT COVERED BY DENTAL INSURANCE? ☐ YES ☐ NO

POLICY HOLDER IS? ☐ MOM ☐ DAD ☐ OTHER: _____

ADDRESS OF POLICY HOLDER **(IF DIFFERENT FROM CHILD)**: _____

_____

_____

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

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

INSURANCE COVERAGE IS ONLY AN ESTIMATION.

GUARANTOR IS RESPONSIBLE FOR ALL PORTIONS NOT COVERED BY INSURANCE.

GUARDIAN'S SIGNATURE _____ DATE _____

RELATIONSHIP IF OTHER THAN PARENT SIGNING _____