Please take a few minutes to complete the following information so we can better care for your child's dental needs.

How did you hear about us? ☐ Insurance ☐ Internet ☐ Friend ☐ Dentist:______________ ☐ Other:________________

Patient and Family Information

Child's Name:____ Birthday:__________ ☐ Male ☐ Female
(First and Last Name)

Home Address:____ Child SS#___________________________

City:___________________________ State:____________ Zip:__________________________

School:____ Grade:____________________

Cell phone_______________ Email__________________________________Would you prefer: ☐ Email ☐ Text ☐ Phone

Please list any other persons you authorize to bring child for visits and consent for future treatment:

Name __________________________ Phone_______________ Relation to child___________________

Name of person bringing child to appointment today. _____________________________________

Relation to child________________________ Phone number_______________________________

Are you the LEGAL guardian of this child and legally able to give consent for treatment? Yes__ No__

If NO, can you provide a notarized statement from the legal guardians allowing you to consent for child's treatment? Yes___ No__

Address: ☐ Same as above or: ____

____

Child's Dental History

Former Dentist:____________________________Date of last dental visit:________________

What was done at your last dental visit?____

Please check all that apply to child:

Tooth Pain____ Thumb/Finger Sucking____ Pacifier User____

Cavities ____ Fillings or Crowns ____ Extracted tooth____

Grinding Teeth____ Bottle Feeding ____ Breast Feeding ____

Has your child had sedation for dental work?______If yes, explain _______________________

____

____

____

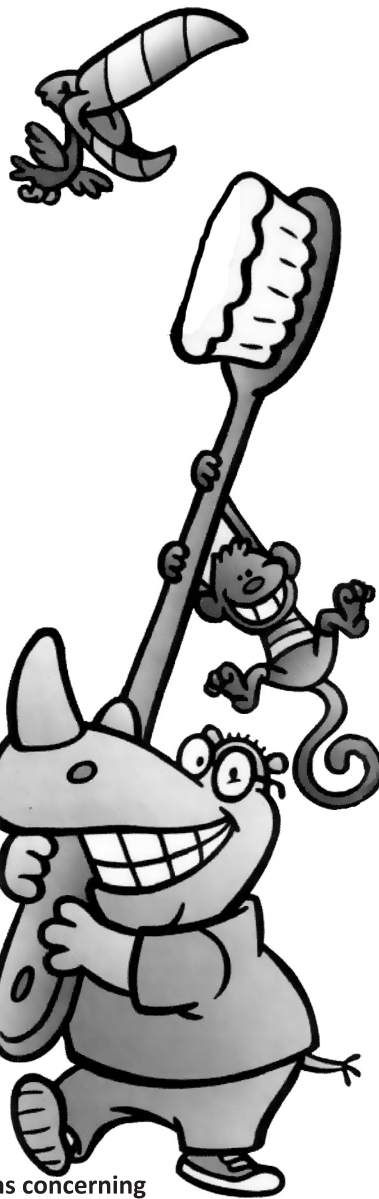
Child's Health History:

Pediatrician:_________________________________ Office Phone: __________

Please check all that apply to your child

Current Medications:

- ☐ Seasonal Allergies
- ☐ Allergy to foods_______
- ☐ Anemia
- ☐ ADHD
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Heart Mumur
- ☐ Hepatitis- Type____
- ☐ Tuberculosis
- ☐ Developmental Delay
- ☐ Sensory Disorder
- ☐ Behavioral Issues
- ☐ Epilepsy: ___ Last seizure ________
- ☐ Allergy to Medications: List-____
- ☐ Operations____________________
- ☐ Sedations ______________________



Primary Dental Insurance of Parent or Guardian

Insurance Company _______________________ If Delta Dental, what State:_________

Policy Holder ____________________________ Relationship to Patient ___________

Birthday _____________ Social Security #____________ Home Phone ______________

Address ____

City _________________________________ State __________ Zip _____________

Employer ____

Office Policy:

Please review our office policies and initial next to each. If you have any questions concerning our policy, please feel free to discuss this with us BEFORE the start of your appointment.

____All fees will be presented to you with estimated insurance coverage. I understand that I am financially responsible for all treatment completed in the case my insurance company denies payment or pays differently than estimate presented to me.

____Cancellations are sometimes unavoidable. I understand that I must cancel any treatment appointment with 48 hours notice to avoid a cancellation fee of $50. For exams that are canceled with less than 48 hours notice there will be a cancellation fee of $25.

____Parents are welcome to accompany their child during cleanings and exams in the open bay area. Please respect the privacy of our office staff and other patients, by limiting your photos to that of your children only and refrain from taking VIDEO. Absolutely NO use of cell phones, no pictures or videos are allowed while your child is receiving dental treatment. The doctor reserves the right to stop the treatment if you are using your phone.

____Behavior Management: This may carry a fee that you will be responsible for in the case that your child is unable to cooperate for treatment using conventional methods and laughing gas. The doctors and assistants do not physically restrain children for treatment. If your child is unable to cooperate for treatment, your options for behavior management will be given. We will inform you of your options and any insurance coverage if this case should arise.

Yes____ or No____ Give permission to Pediatric Dental Group to take photographs and video of my child while in office or at local events, for the purpose of internal or external use, publish the same in print and / or electronically. I also agree to the usage by the office staff for the child's records and any use of such photographs with or without name and for any lawful purpose, including publicity, illustration, advertising, media releases and web content for one year with no compensation.

Signature of Parent or Guardian ______________________________ **Date** ____________