Pediatric Dentistry PLC

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PARENT/GUARDIAN INFORMATION

Full Name:	Date of Birth:	Occupation:
Address:	Social Security:	Employer:
City, State, Zip:	Marital Status:	E-Mail:
Cell Phone:	Home Phone:	Work Phone:

Relationship to patient: ○ Mother ○ Father ○ Grandparent ○ Legal Guardian

SECONDARY PARENT/GUARDIAN INFORMATION

Full Name:	Date of Birth:	Occupation:
Address:	Social Security:	Employer:
City, State, Zip:	Marital Status:	E-Mail:
Cell Phone:	Home Phone:	Work Phone:

Relationship to patient: ○ Mother ○ Father ○ Grandparent ○ Legal Guardian

Do we have permission to leave you messages containing detailed dental and medical information regarding your child? **YES** or **NO** If yes, what it the best way to reach you:
○ Phone ○ E-mail

Consent for Dental Treatment

I give my consent for Dr. Sarah Welch and Dr. Ashley Turrittin and associates at Pediatric Dentistry to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Welch/Dr. Turrittin and associates to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child's teeth for diagnostic or educational purposes. I understand that the dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Welch/Dr. Turrittin and associates will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. **I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.**

Requirement for Filing Insurance Claims: To initiate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance fails to pay, for any reason, within 30-days of treatment. I hereby authorize payment of insurance benefits directly to Pediatric Dentistry P.L.C. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in attempt to collect this amount.

PRINT NAME_____ SIGN NAME _____

Date _____

Today's Date: _____ [OFFICE USE ONLY - wt: _____]

Patient's Full Name:_____Age: _____ Preferred Name: _____ **Date of Birth:** _____ Sex: _____

Purpose of visit: _____Concerns:_____

Child's interests: _____ Child's SSN#: _____

Does the patient have any special needs? _____Is the patient adopted?: ◯(Y) ◯(N)

Patient's learning: ◯slow ◯average ◯accelerated Patient's school: _____

Medical History

Patient's Pediatrician:_____Phone:_____Last exam:_____

Is the patient under a physician's care? ◯(Y) ◯(N) If yes, reason: _____

Physician's name and type of doctor: _____ Phone: _____

Is the patient taking any medications (incl. over the counter)?◯(Y) ◯(N) If yes, please list: _____

Is the patient allergic to any medication? ◯(Y) ◯(N) Please list with reactions: _____

Has the patient ever had a history or difficulty with any of the following medical conditions?

Y	N		Y	N		Y	N	
◯	◯	Antibiotic pre-medication for dental work?	◯	◯	Asthma or lung problems	◯	◯	Bleeding Disorder or Hemophilia
◯	◯	Congenital Birth Defects/Syndrome			Last attack:_____	◯	◯	Immunologic Disorder: HIV/AIDS/ARC
◯	◯	Cleft lip/palate	◯	◯	Brain Injury	◯	◯	Pneumonia (when? _____)
◯	◯	Eyes ◯ Right ◯ Left ◯ Both	◯	◯	Premature	◯	◯	Diabetes (*NIDDM or IDDM*_____ *x day*)
◯	◯	Sinus	◯	◯	Seizures, Epilepsy or Convulsions	◯	◯	Sickle Cell Anemia or Trait
◯	◯	Hearing impairment ◯ Right ◯ Left ◯Both	◯	◯	Down's Syndrome	◯	◯	Rheumatic Fever or Scarlet Fever
◯	◯	Earaches/infections	◯	◯	Cerebral Palsy	◯	◯	Implanted Shunts, Pins, Screws, Rods
◯	◯	Nosebleeds	◯	◯	Delayed Development	◯	◯	Cancer, Malignancy, Leukemia or Lymphoma
◯	◯	Liver/Jaundice			(*Approx age child functions* _____)			
◯	◯	Hepatitis	◯	◯	Sensory issues: _____	◯	◯	Tuberculosis or Previous Positive Test
◯	◯	Kidney	◯	◯	Autism Spectrum Disorder	◯	◯	Physical or Emotional Abuse
◯	◯	Bladder	◯	◯	Speech problems	◯	◯	Emotional or Behavioral Problems
◯	◯	Heart Condition: ◯ Current ◯ Repaired	◯	◯	Learning Disability	◯	◯	Psychiatric Problems
◯	◯	Heart Murmur: ◯Innocent ◯ Pathological	◯	◯	Diagnosed with ADD/ ADHD			_____
◯	◯	Bruising/bleed easily	◯	◯	Bone Disorder	◯	◯	Latex Allergy or Sensitivity

[OFFICE USE ONLY – ASA ____ , Notes: _____]

Dental History

Is this the child's first dental visit? ◯(Y) ◯(N) If no, previous dentist:_____

Date of last visit: _____ How was his/her experience?: _____ Were any x-rays taken? ◯(Y) ◯(N)

Child's attitude toward the dentist or dental care: _____

Name of child's orthodontist (if applicable): _____ Orthodontic Status: ◯(not started) ◯(currently in braces) ◯(completed)

Has the patient had any injuries to teeth, mouth, or head? ◯(Y) ◯(N)

If yes, please describe:_____

Is your child currently having or had any of the following dental conditions?

Y	N		Y	N		Y	N	
◯	◯	Bad Breath / Halitosis _____	◯	◯	Cold Sores or Fever Blisters	◯	◯	mouth-breathing
◯	◯	Popping or Soreness of Jaws	◯	◯	Missing or Extra Teeth _____	◯	◯	teeth grinding
◯	◯	Bleeding Gums			Or habits?	◯	◯	nursing _____
◯	◯	Dental Infection or Abscess _____	◯	◯	thumb/finger sucking _____	◯	◯	bottle-feeding _____
◯	◯	Stained or Discolored Teeth	◯	◯	pacifier use _____	◯	◯	sippy cup w/ juice _____
◯	◯	Pain from Teeth _____	◯	◯	nail biting _____			

Is your water fluoridated? ◯(Y)◯(N) Does the patient take fluoride supplements? ◯(Y)◯(N) Does the patient use fluoridated toothpaste? ◯(Y) ◯(N)

How often does the patient brush his/her teeth_____ With adult supervision? ◯(Y) ◯(N) How often does the patient floss?:_____

How would you describe your child's current oral health? ◯ Excellent ◯ Good ◯ Fair ◯ Poor

[OFFICE USE ONLY: Notes: _____]

[OFFICE USE ONLY - Reviewed by : _____ (initials) Date: _____] V.1