PEDIATRIC PATIENT INFORMATION

Please complete the **FRONT** and **BACK** of this form and return to the receptionist. Thank you!

Personal Information

Today's Date: ___________________________

Name: ____

Birthdate: _____________________ Sex: Male Female

Preferred to be Called: ________________________________

Age: _______________ Grade: _____________

Address: ____

School: ____

____
City State Zip

Father's Name: __________________________________

Mother's Name: __________________________________

Home Phone: ( ) ___________________________

Brothers: ______________________________________

Head of Household: __________________________________
(This is for billing purposes. Party responsible for family account)

Sisters: ____

In Case of Emergency, Contact: _________________________

Any Pets: ______________________________________

Contact Relationship to Patient: _________________________

Contact #: ______________________________________

E-mail and Special Offers

Would you like to be added to our e-mail directory to receive special offers and monthly newsletters? YES NO

If yes, please list your e-mail address: ____

Medical/Dental Information

Name of Family Physician: ______________________________

Date of last complete physical: ______________________

Physician's Address: ___________________________________

Results of physical: _______________________________

____
City State Zip

Physician's Phone No.: _____________________________

Dental History

Date of last dental visit: NEVER or _______________

Reason for last visit: ___________________________

By which dentist: _______________________________

Any previous un-happy visits? YES NO

Has your child complained about any dental problems? YES NO

If yes, please explain: _________________________________

Any injuries to mouth, teeth or head? YES NO

If yes, explain: ________________________________

Any mouth habits (thumb sucking, nail biting, mouthbreathing, etc)

____

Any lost teeth? _______________________________________

Does your child brush daily? YES NO

Do you assist your child with brushing? YES NO

How often: ______________________________________

Is dental floss used? YES NO

Are disclosing tablets used? YES NO

How does your child receive fluoride: WATER TOOTHPASTE DENTIST VITAMINS TABLETS NONE OTHER: ______________________

Child's attitude to dentistry: GOOD BAD UNSURE

____

____

Is your child in good health? ____ YES NO

Is your child under the care of a physician? ____ YES NO

Is your child taking any medications? ____ YES NO

What is your child's WEIGHT: ______________________ HEIGHT: __________________

Has your child ever been hospitalized? ____ YES NO

Has your child ever had surgery? ____________________ YES NO

Are there any psychological or emotional problems you would like to bring to our attention? YES NO

____

Briefly explain your child's eating habits: ____________________

Does your child have, or has he/she ever had, ANY of the following? Please circle all that apply:

Rheumatic Fever
Rheumatic Heart Disease
Congenital Heart Disease
Heart Murmur
**Allergies (list below in space provided)
Asthma
Hay Fever
Arthritis or Rheumatism (painful swollen joints)
Diabetes or Blood Sugar Problems
Any Prolonged Bleeding
Bruises Easily
Kidney or Bladder Problems

AIDS/HIV
Anemia or Blood Disorders
Tuberculosis Pneumonia
Liver Problems, Jaundice or Hepatitis
Glandular or Hormonal Problems
Accidents or Severe Infections
Convulsions, Seizures, Fainting or Epilepsy
High or Low Blood Pressure
Speech, Learning or Hearing Disorders
Childhood Illnesses
Immunizations: UP TO DATE NOT UP TO DATE
Other (explain): ____________________

If you circled any above, please explain: ____________________

____

**List any Allergies (medications or other): ____________________

Primary Dental Insurance Information

Name of Insurance Company: ____________________ Phone No: ____________________
Name of Policyholder: ____________________ Policyholder's SSN: ____________________
Patient's Relationship to Policyholder: Self/Spouse/Child/Other Policyholder's DOB: ____________________
Employer's Name Providing Insurance: ____________________ Group No.: ____________________

Secondary Dental Insurance Information

Name of Insurance Company: ____________________ Phone No: ____________________
Name of Policyholder: ____________________ Policyholder's SSN: ____________________
Patient's Relationship to Policyholder: Self/Spouse/Child/Other Policyholder's DOB: ____________________
Employer's Name Providing Insurance: ____________________ Group No.: ____________________

I authorize the assignment of my insurance benefits to Dental Innovations.

____________________ ____________________
Parent, or Legal Guardian Date

Referral Information

How were you referred to our office? Please circle all that apply.

Insurance Company
Friend (Please list their name: ____________________)
Cosmetic Postcard
Dental Office Employee (Please list name: ____________________)
Other (Please list: ____________________)

Yellow Pages: JO CO FEIST SWB
Internet/Family Dental Care Website
Val-Pak Offer
Walk-In
Drive By

Treatment Authorization and Acknowledgement

I hereby certify the foregoing information is correct and true. Because the above named patient is a MINOR, it becomes necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Authorization is hereby granted as such. Furthermore, I WILL BE RESPONSIBLE FOR ANY PROFESSIONAL FEES INCURRED FOR DENTAL SERVICES TO MY CHILD.

I also understand that **PAYMENT IS DUE AT THE TIME OF TREATMENT** unless other arrangements have been made in writing.

I HAVE READ AND UNDERSTAND AND AGREE TO THE ABOVE POLICY.

____ _________________________________

Parent, or Legal Guardian Date