Welcome to

Children's Dentistry of AV

PATIENT INFORMATION

____
First Name Middle Last Name Nickname

Age____ Date of Birth________________ ☐Male ☐Female Phone (_____)____________________

Home Address_____________________________City___________________ ZIP________________

Child's School____Grade_________________

First names of child's siblings:____

Reason for visit:____

How did you hear about our office?____

RESPONSIBLE PARTY

Father/Guardian
Name_______________________________________
Married_______ Single______ Divorced______
Address (if different from patient's):
____
____
SS#_______________Birth Date____________
Home Phone(_____)____________________
Work Phone(_____)_____________________
Cell Phone(_____)______________________
Email Address___________________________
Employer_______________________________
Occupation_____________________________

Mother/Guardian
Name_______________________________________
Married_______ Single______ Divorced______
Address (if different from patient's):
____
____
SS#_______________Birth Date____________
Home Phone(_____)____________________
Work Phone(_____)_____________________
Cell Phone(_____)______________________
Email Address___________________________
Employer_______________________________
Occupation_____________________________

Emergency Contact:
Name ____Phone(_____)___________________

INSURANCE

Primary Dental Insurance____________________
Group#___________________________________
Policy Holder Name__________________________

Secondary Dental Insurance__________________
Group#___________________________________
Policy Holder Name__________________________

DENTAL HISTORY

Yes No

☐ ☐ Is this your child's first visit to the dentist?

If no, name of the previous dentist______________________Date of the last visit?____________

☐ ☐ Does your child brush teeth daily?

☐ ☐ Does your child floss daily?

☐ ☐ Does your child receive fluoride supplements?

☐ ☐ Any unhappy medical or dental visits? If yes, please explain:_______________________________

☐ ☐ Does your child have any of the following habits? Please circle all that apply.

Thumb/Finger Sucking/Pacifier   Grinding   Nail biting   Mouth Breathing   Nursing Bottle/Breast-feeding

MEDICAL HISTORY

Child's Pediatrician:_________________________City___________________Phone(____)____________

Date of last physical examination______________________ Results_______________________________

Yes No

☐ ☐ Is your child currently taking any medication? ____

☐ ☐ Has your child ever been hospitalized?____

☐ ☐ Has your child ever had surgery?____

☐ ☐ Is your child allergic to anything?____

☐ ☐ Does your child require antibiotics for dental work because of a heart defect, heart murmur, prosthesis, shunt or other medical reason?

Has your child ever had any of the following medical conditions?

Yes No

☐ ☐ Abnormal Bleeding

☐ ☐ ADHD/ADD

☐ ☐ AIDS/ADD

☐ ☐ Anemia

☐ ☐ Artificial Joints/Heart Valves

☐ ☐ Asthma

☐ ☐ Autism

☐ ☐ Brain Injury

☐ ☐ Cancer/Chemotherapy/Radiation

☐ ☐ Cerebral Palsy

☐ ☐ Cleft Lip/Palate

☐ ☐ Convulsion/Epilepsy

☐ ☐ Developmentally Delayed/Special Needs

☐ ☐ Diabetes

☐ ☐ Growth/Developmental Problems

Yes No

☐ ☐ Hearing Impairment

☐ ☐ Heart Murmur/Defects

☐ ☐ Hemophilia

☐ ☐ Hepatitis

☐ ☐ Kidney/Liver Disease

☐ ☐ Latex Allergy

☐ ☐ Premature Birth

☐ ☐ Psychiatric Care/Counseling

☐ ☐ Rheumatic Fever

☐ ☐ Sensory Disorder

☐ ☐ Skin Rash

☐ ☐ Syndrome:___________________________

☐ ☐ Tuberculosis (TB)

☐ ☐ Other______________________________

Do you wish to talk to the doctor privately about a special concern? ☐Yes ☐No

CONSENT

I understand that the information that I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the office staff of Children's Dentistry of AV to perform the necessary dental services my child may need, using the appropriate materials and medicament. Parents/legal guardians will be consulted before any treatment is started. The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature of Parent or Guardian____Date________