



# WELCOME!

Thank you for choosing Dr. J Pediatric Dentistry for your child's dental care!

## PATIENT INFORMATION

Patients Name: \_\_\_\_\_ DOB: \_\_\_\_\_ GENDER: M F

Street Address: \_\_\_\_\_

City State Zip

Primary Number: \_\_\_\_\_ Alternate Number: \_\_\_\_\_

I understand that I will receive text message communications to the number provided on this form related to appointment reminders, healthcare information and billing matters. I understand that I may be charged message and data rated by my wireless carrier. Such messages may be generated by an automated messaging system and I may opt-out of this service in writing to Dr. J Pediatric Dentistry.

Who is accompanying the patient today (name)? \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Email: \_\_\_\_\_ Is your child a ward of the state? YES NO

If Yes, case worker's name, phone number and email: \_\_\_\_\_

## PARENT INFORMATION

### GUARDIAN 1

V \_\_\_\_\_ Gender: M F

D.O.B: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: Single Married Divorced

Separated Widowed Domestic Partnership

Primary Number: \_\_\_\_\_

Email: \_\_\_\_\_

If address is different from patients please list here:

\_\_\_\_\_

\_\_\_\_\_

### GUARDIAN 2

Name: \_\_\_\_\_ Gender: M F

D.O.B: \_\_\_\_\_ SSN: \_\_\_\_\_

Marital Status: Single Married Divorced

Separated Widowed Domestic Partnership

Primary Number: \_\_\_\_\_

Email: \_\_\_\_\_

If address is different from patients please list here:

\_\_\_\_\_

\_\_\_\_\_

## DENTAL INSURANCE INFORMATION

### PRIMARY COVERAGE

Name of Insured: \_\_\_\_\_

D.O.B: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Insurance Claims Address: \_\_\_\_\_

\_\_\_\_\_

Group/Policy # \_\_\_\_\_

Insurance ID # \_\_\_\_\_

### SECONDARY COVERAGE

Name of Insured: \_\_\_\_\_

D.O.B: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Phone # \_\_\_\_\_

Insurance Co: \_\_\_\_\_

Insurance Claims Address: \_\_\_\_\_

\_\_\_\_\_

Group/Policy # \_\_\_\_\_

Insurance ID # \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Are you being referred by another office? If yes, which office? \_\_\_\_\_

Phone: \_\_\_\_\_ Doctor: \_\_\_\_\_

## DENTAL HISTORY

### DENTAL CONCERNS

What is the primary reason for today's visit? :  Cleaning  Trauma/Dental Emergency  Consult for Decay

Has your child ever been to the dentist? :  Yes  No

Do you think your child will react well to treatment? :  Yes  No

Please describe any tips/tricks that will help our team provide a positive experience for your child's visit: \_\_\_\_\_

**DENTAL HABITS.** Does your child currently...(check all that apply)

- Suck Thumb/Finger     Suck/Bite Lips     Bite/Chew Nails     Tongue Thrust     Bottle Feed  
 Use Pacifier     Tongue/Cheek Chew     Clench/Grind Teeth     Mouth Breather     Breast Feed

**HYGIENE ROUTINE.** Check all that apply.

- Fluoride Toothpaste     Consume Fluoridated Water     Brushing by Child: \_\_\_\_\_/day     Snack between Meals - Type of snacks: \_\_\_\_\_  
 Fluoride Mouthwash     Dental Floss: \_\_\_\_\_/week     Brushing by Parent: \_\_\_\_\_/day \_\_\_\_\_

## MEDICAL HISTORY

Are immunizations current? :  Yes  No

Date of Last Exam: \_\_\_\_\_

Child's Physician/Office: \_\_\_\_\_ Phone # \_\_\_\_\_

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain): \_\_\_\_\_

Is your child followed by a specialist? :  Yes  No If yes, provide name & contact information: \_\_\_\_\_

Has your child been diagnosed and/or treated for any of the following...(mark yes or no)

	YES	NO		YES	NO		YES	NO
Asthma/Reactive Airway			Down Syndrome			Mono		
Anemia/Blood Disorder			Deaf/Hearing Problems			Mental, Cognitive, Social Delay		
Autism Spectrum			Diabetes			Premature/Low Birth Weight		
Abnormal Bleeding/Hemophilia			Eating Disorder			Rheumatic Fever		
ADD/ADHD			Heart Murmur			Renal Dialysis		
Bronchitis/Chronic Coughing			Heart Disorder			Radiation/ Chemotherapy		
Behavior Problems			Heart Surgery/Attack/Other			Stroke		
Cystic Fibrosis			Hay fever/Sinus Trouble			Speech Delay		
Congenital Birth Defects			High/Low Blood Pressure			Sickle Cell Disease/Trait		
Cerebral Palsy			Immune Disorder/ HIV/AIDS			Stomach Ulcers/GI Problems		
Cleft Lip/Palate			Kidney Problems			Tonsillitis		
Convulsions, Epilepsy/Seizures			Lung Disease/Problems			Thyroid Trouble		
Cancer			Liver Disease/Jaundice/Hepatitis			Tuberculosis		
Other (please specify): _____								

Please list any and all allergies: \_\_\_\_\_  
(drugs, foods, seasonal, latex) \_\_\_\_\_

Please list any medications or vitamins that the patient is taking: \_\_\_\_\_

Consent for X-Rays (if needed) Essential for diagnosing tooth decay and other abnormalities. YES    NO  
 Consent for Fluoride: To help fight tooth decay and strengthen developing teeth. YES    NO

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Fishers Pediatric Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Fishers Pediatric Dentistry all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

**Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_