

• **PRIMARY DENTAL INSURANCE:**

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient: _____

Policy Owner's Date of Birth: ____/____/____ SS #: _____

Policy Owner's Employer: _____

- Federal law requires that the parent or guardian who brings the child to the appointments is responsible for the incurred fees.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.
- I certify this information is true and correct to the best of my knowledge.
- I will notify you of any changes in my child's health status or the above information.
- I understand that Dentistry For Children files insurance claims electronically. This is acceptable to me.

_____ Date _____

Signature

relationship to patient

DENTAL HEALTH:

Why did you bring your child to the dentist today? _____

How long has it been since your child's last exam? _____ last cleaning? _____

For most drinking & cooking do you use: town water well-water bottled water

If well or bottled, has water been tested fluoride?Yes No

Results? _____

Does your child take fluoride supplements? Yes No

Dose _____ Frequency _____

Have there been any injuries to the face, mouth or teeth?...Yes No

Please give dates and descriptions _____

Has your child ever sucked a thumb or fingers?..... Yes No

• Pacifier?..... Yes No

Any other habits? _____ For thumb, pacifier or other habits? _____

Does your child have:

Snoring..... Yes No

Daytime mouthbreathing.....Yes No

Nighttime mouthbreathing..... Yes No

Tooth grinding..... Yes No

Bedwetting now..... Yes No

Hearing deficiency..... Yes No

Frequent middle ear infections..... Yes No

Environmental allergies..... Yes No

Taking medications? _____

History of sleep apnea.....Yes No

Restless Sleep..... Yes No

Speech problems..... Yes No

Have you been informed of any missing or extra permanent teeth?Yes No

Are there any unusual sounds in ear (clicking) during eating? Yes No

Has your child ever had an orthodontic examination or orthodontic treatment? Yes No

Does your child use a sippy cup?.....Yes No

Did your child go to sleep with a bottle, with a sippy cup, or while nursing?Yes No

Until what age? _____

- Is your child nervous or frightened during dental visits? If yes, please circle
Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

- It would be helpful if you would indicate below what things you are looking for most in choosing a pediatric dentist.

- Has your child had any unfavorable medical or dental experience?.....Yes No

If so, please explain _____

MEDICAL HEALTH:

- Is your child in good health?..... Yes No
- Date of last physical examination: _____
- Is your child now under the care of a physician?..... Yes No
If so, what condition being treated? _____
- Did your child have trouble at birth or during the early years?..... Yes No
Please describe _____
- Name of Pediatrician or Family Physician _____
Address & Phone _____
- Has your child had any serious illness or injury?..... Yes No
If so, what was the illness or injury? _____ Date _____
- Has your child received any blood transfusion?..... Yes No
In what years? _____
- Has your child ever been hospitalized or had surgery?..... Yes No
Date _____ Reason: _____
Date _____ Reason: _____
- Has your child's tonsils or adenoids been removed?..... Yes No
If yes, when _____

Does your child have or had your child had any of the following?

- | | | | |
|--|--|---------------------------------|--|
| Rheumatic fever or rheumatic heart disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart murmur | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital heart lesions | <input type="checkbox"/> Yes <input type="checkbox"/> No | Low blood pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physician has recommended antibiotics before dental procedures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid problem | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Other cardiovascular Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Environmental allergies | <input type="checkbox"/> Yes <input type="checkbox"/> No | Growth problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hay fever or sinus problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stomach ulcers | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma or breathing problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hives or skin rash | <input type="checkbox"/> Yes <input type="checkbox"/> No | Birth defect (please describe): | |
| | | Hearing problems | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Fainting spells or seizures Yes No
 Diabetes Yes No
 Hepatitis, jaundice or liver problems
 Yes No
 (if jaundice, when newborn?) Yes No
 Arthritis Yes No
 Limits on physical activities Yes No

Learning problems Yes No
 Behavior problems Yes No
 Mental problems Yes No
 Blood transfusion Yes No
 HIV (AIDS) Yes No
 Other Yes No

- Has your child had abnormal bleeding with previous extractions, surgery, or trauma?
Yes No

- Has your child been tested for sickle cell anemia?.....Yes No
 If yes, what was the result?

- Does your child take any drug or medicine?.....Yes No
 If so, what/how often:

- Does your child take any vitamins, supplements?.....Yes No
 Please list:

- Has your child ever had an allergic reaction to:(if yes, please describe)

Aspirin or Ibuprofen Yes No
 Penicillin or other antibiotics Yes No
 Novocaine, Xylocaine or
 other local anesthetics Yes No
 Other

Codeine Yes No
 Sulfa drugs Yes No
 Foods Yes No
 Latex Yes No

- Does your child use any complementary or alternative medicines or supplements?
Yes No

Please list _____

- Does your child have any mental or physical disability?..... Yes No
 If so, please explain _____

- Does your child have any disease, condition or problem not listed above that you think we should know about?_____

- What are her/his hobbies or interest?

Consent:

1. The undersigned hereby authorizes the taking of x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Sina/Dr. Hibler to make a thorough diagnosis of your child's dental needs.
2. I also authorize Dr. Sina/Dr. Hibler to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment of my child.
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Sina/Dr. Hibler choose and employ such assistance as deemed fit to provide recommended treatment.

Parent (Guardian)

Date

SUMMARY/NOTES:

Date

Signature of Dr. Maryam Sina/Dr. Jeanne A. Hibler

