children's dental
pediatric specialists

CHILD'S NAME: First_____ Last_____ Male Female
Birthdate:_____ Age: _____School: _____
Home address:_____
City, State, Zip Code_____
Child lives with: (circle) Father Mother Both Other
Marital status of parents: (circle one) Married Single Divorce Separate Widowed

FATHER: _____ Home phone: _____Cell Phone: _____
Social Security Number:_____ Birth date:_____
Father's Employer: _____ Work Phone: _____
Employer Address_____
Home address if different than child's _____

MOTHER: _____ Home phone: _____Cell Phone: _____
Social Security Number:_____ Birth date:_____
Mother's Employer: _____ Work Phone: _____
Employer Address_____
Home address if different than child's _____

PAYMENT OPTIONS: Method of payment (please circle one)
Cash, Check or Credit Card at time of service
Insurance and co-pay at time of service Medicaid and co-pay if applicable

Emergency Contact: _____

PRIMARY DENTAL INSURANCE:
Name:_____ Address_____
Phone number: _____
Policy holder:_____ Member ID #_____
Group #: _____ Group Name:_____

SECONDARY DENTAL INSURANCE:
Name:_____ Address_____
Phone number: _____
Policy holder:_____ Member ID #_____
Group #: _____ Group Name:_____

HEALTH (medical) INSURANCE INFO: Name_____
Address: _____ Phone: _____
Insured Persons Name: _____

Whom may we thank for referring you to our office?

DENTAL HISTORY: Why is your child here today? _____
Is there a specific problem? _____
Is your child currently taking fluoride? _____How often? _____
Has your child been to the Dentist before? _____Date: _____
How was your child's experience? _____
Has your child had x-rays before? _____Date:_____
Is your child currently on the bottle? _____Pacifier? _____Sippy cup? _____
Nursing? _____Thumb sucking? _____Grinding? _____
Do you currently help your child brush and floss? _____
How often does he/she brush? _____
Does your child have TMJ/TMD? _____

MEDICAL HISTORY: Name of Physician: _____
Date of last physical exam: _____ Any findings: _____
Is your child's immunization up to date? _____ Date: _____
Date of your child's last tetanus _____Booster _____ any immunizations due?_____
Is your child currently taking medication? _____ If yes, what? _____
Is your child currently under the care of a physician for any reason? _____
If yes, for what? _____ Date: _____
Has your child ever had a traumatic medical or dental injury? _____
If yes, for what? _____ Date: _____
Has your child ever been hospitalized? _____
If yes, for what? _____ Date: _____

DOES YOUR CHILD HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING?
PLEASE CIRCLE ALL THAT APPLY TO YOUR CHILD:

Autism	Y	Multiple ear infections	Y	Radiation Treatment	Y	Kidney Disease	Y
ADHD	Y	Endocrine system	Y	Vomiting/Diarrhea	Y	Respiratory Treatment	Y
AIDS	Y	Fainting	Y	Respiratory Problem	Y	Cancer/Tumor	Y
Allergies	Y	Hearing/Sight	Y	Rheumatic Fever	Y	GI System	Y
Anemia	Y	Heart Murmur	Y	Seizures	Y	Tubes in ears	Y
Artificial Joints	Y	Heart Condition	Y	Tuberculosis	Y	Liver Disease	Y
Asthma	Y	Head Injury	Y	Down Syndrome	Y	Mental Disorder	Y
Blood disease/ disorder	Y	Frequent/recurrent headache's	Y	Blood Transfusion If yes date	Y	Mental/Physical Developmental Delay	Y
Breathing/Lung Problems	Y	Allergies/Adverse reaction to medication	Y	Behavioral/ Learning disorder	Y	Pregnancy due date _____	Y
Any other medical conditions not listed	Y	If yes what type of medication? _____		Frequent infections What type _____	Y	Congenital birth Defects	Y

I have read the above and have answered them to the best of my knowledge. I have updated this form as requested.

Signature_____Date_____

Signature_____Date_____

Signature_____Date_____