Please take a few minutes to complete the following information so we can better care for your child's dental needs.

How did you hear about us? ☐ Insurance ☐ Internet ☐ Friend ☐ Dentist:_____ ☐ Other:_____

Patient and Family Information

Child's Name:_____ Birthday:_____ ☐ Male ☐ Female
(First and Last Name)

Home Address:_____ Child SS#_____

City:_____ State:_____ Zip:_____

School:_____ Grade:_____

Cell phone_____ Email_____Would you prefer: ☐ Email ☐ Text ☐ Phone

Please list any other persons you authorize to bring child for visits and consent for future treatment:

Name _____ Phone_____ Relation to child_____

Name of person bringing child to appointment today. _____

Relation to child_____ Phone number_____

Are you the LEGAL guardian of this child and legally able to give consent for treatment? Yes__ No__

If NO, can you provide a notarized statement from the legal guardians allowing you to consent for child's treatment? Yes___ No__

Address: ☐ Same as above or: _____

_____

Child's Dental History

Former Dentist:_____Date of last dental visit:_____

What was done at your last dental visit?_____

Please check all that apply to child:

Tooth Pain____	Thumb/Finger Sucking____	Pacifier User____
Cavities ____	Fillings or Crowns____	Extracted tooth____
Grinding Teeth____	Bottle Feeding____	Breast Feeding ____

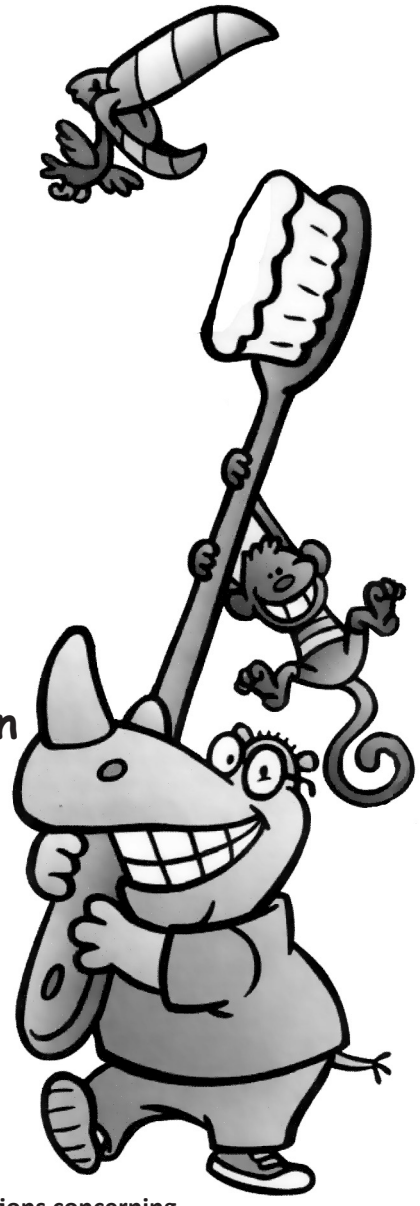
Has your child had sedation for dental work?_____If yes, explain _____

_____

_____

_____

Child's Health History:



Pediatrician:_____ Office Phone: _____

Please check all that apply to your child

Current Medications:

☐ Seasonal Allergies ☐ Allergy to foods_____ ☐ Anemia

☐ ADHD ☐ Asthma ☐ Cancer

☐ Diabetes ☐ HIV/AIDS ☐ Heart Mumur

☐ Hepatitis- Type____ ☐ Tuberculosis ☐ Developmental Delay

☐ Sensory Disorder ☐ Behavioral Issues ☐ Epilepsy: ___ Last seizure _____

☐ Allergy to Medications: List-_____

☐ Operations_____ ☐ Sedations _____

Primary Dental Insurance of Parent or Guardian

Insurance Company _____ If Delta Dental, what State:_____

Policy Holder_____ Relationship to Patient _____

Birthday _____ Social Security #_____ Home Phone _____

Address_____

City _____ State _____ Zip _____

Employer_____

Office Policy:

Please review our office policies and initial next to each. If you have any questions concerning our policy, please feel free to discuss this with us BEFORE the start of your appointment.

____All fees will be presented to you with <u>estimated</u> insurance coverage. I understand that I am financially responsible for all treatment completed in the case my insurance company denies payment.

____Cancellations are sometimes unavoidable. I understand that I must cancel any <u>treatment</u> appointment with 24 hour notice to avoid cancellation fee of $50. This is for treatment appointments only.

____ Parents are welcome to accompany their child during cleanings and exams in the open bay area.

Please respect the privacy of our office staff and other patients, by limiting your photos to that of your children only and refrain from taking VIDEO.

____ Behavior Management: This may carry a fee that you will be responsible for in the case that your child is unable to cooperate for treatment using conventional methods and laughing gas. The doctors and assistants do not physically restrain children for treatment. If your child is unable to cooperate for treatment, your options for behavior management will be given. Options are different for every patient and can range from medical immobilization to general anesthesia. We will inform you of your options and any insurance coverage if this case should arise.

Yes____ or No____ Give permission to Pediatric Dental Group to take photographs and video of my child while in office or at local events, for the purpose of internal or external use, publish the same in print and / or electronically. I also agree to the usage by the office staff for the child's records and any use of such photographs with or without name and for any lawful purpose, including publicity, illustration, advertising, media releases and web content for one year with no compensation.

Signature of Parent or Guardian _____ **Date** _____