Specialists in Pediatric Dentistry

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PATIENT INFORMATION

Name: ______________ Nickname: ______________ Today's Date: ______________

Birth date: __________ Age: ______ Gender: ☐ M ☐ F School: ______________ Grade: ________

Address: ______________ City: ______________ State: ________ Zip Code: __________

Primary number for appointment confirmations: ______________ Email: ______________

Who referred you to our office? ______________ Who is responsible for making appointments: ______________

RESPONSIBLE PARTY INFORMATION

Guardian (1)

Name: ______________ Gender: ☐ M ☐ F

Relationship: ______________

Social Security #: ______________ Birthdate: ______________

Primary Phone #: ______________ ☐ H ☐ C ☐ W

Secondary Phone #: ______________ ☐ H ☐ C ☐ W

Email: ______________ DL #: ______________

Employer: ______________

Employer Phone#: ______________ Occupation: ______________

☐ *Check box if address is the same as patient's listed above.*

Address: ______________

City: ______________ State: _____ Zip Code: ________

Guardian (2)

Name: ______________ Gender: ☐ M ☐ F

Relationship: ______________

Social Security #: ______________ Birthdate: ______________

Primary Phone #: ______________ ☐ H ☐ C ☐ W

Secondary Phone #: ______________ ☐ H ☐ C ☐ W

Email: ______________ DL #: ______________

Employer: ______________

Employer Phone#: ______________

☐ *Check box if address is the same as patient's listed above.*

Address: ______________

City: ______________ State: _____ Zip Code: ________

DENTAL INSURANCE INFORMATION

Primary Coverage

Policyholder's Name: ______________

Policyholder's Birthdate: __________ Relationship: __________

Social Security #: ______________ Member Id #: __________

Insurance Company: ______________ Group #: ________

Claims Address: ______________

Employer: ______________

Employer's Phone #: ______________

Secondary Coverage

Policyholder's Name: ______________

Policyholder's Birthdate: __________ Relationship: __________

Social Security #: ______________ Member Id #: __________

Insurance Company: ______________ Group #: ________

Claims Address: ______________

Employer: ______________

Employer's Phone #: ______________ Occupation: __________

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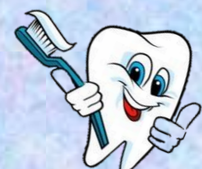


DENTAL HISTORY

Is this your child's first dental visit? ☐ Y ☐ N If no, previous/present dentist: ____________________ Phone #: __________

Date of last visit: __________ Have they ever had a bad experience? ☐ Y ☐ N If yes, please explain: ____________________

____

Were x-rays taken? ☐ Y ☐ N If yes, when? ____________________ Is your child's water fluoridated? ☐ Y ☐ N

HYGIENE ROUTINE (check all that apply)

☐ Dental Floss: ______/week ☐ Brushing by Child: ______/day ☐ Brushing by Parent: ______/day ☐ Fluoride Toothpaste

DENTAL HABITS (check all that apply)

☐ Suck Thumb/Finger ☐ Use Pacifier ☐ Suck/Bite Lip ☐ Bite/Chew Nails ☐ Clench Jaw ☐ Grind Teeth

☐ Bottle-fed Until what age? _____ How many times a day? _____ ☐ Breast-fed until what age? _____ How many times a day? ______

Other, and/or Explain: ____

MEDICAL HISTORY

Child's Pediatrician: ______________________________ Phone #: ____________ Date of Last Exam: ________

Is your child vaccinated? ☐ Y ☐ N Immunization current? ☐ Y ☐ N Current Medications: ____________________

Pharmacy: ________________ Address: ____________________________ Phone #: ______________

History of hospitalization or surgery: ____

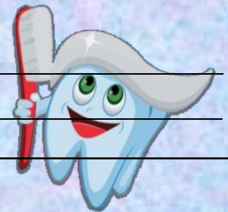
Allergies/Sensitivities: ______________________________ Phobias: ______________________________

DIAGNOSIS/TREATMENT (check all that apply)

☐ ADHD/ADD	☐ Cardiac Disease/Heart	☐ Hepatitis/Liver Disease	☐ Immune Disorder	☐ Anemia/Blood Disorder
☐ Asthma	☐ Bladder/Kidney	☐ Arthritis/Joint Disorder	☐ Bone Disorder	☐ Abnormal Bleeding/Hemophilia
☐ Autism Spectrum	☐ Earaches/Infections	☐ Down's Syndrome	☐ Epilepsy/Seizure	☐ Cognitive/Social Delay
☐ Diabetes	☐ Speech Disorder/Delay	☐ Rheumatic Fever	☐ Cerebral Palsy	☐ Premature/Low Birth Weight
☐ Tuberculosis	☐ Delayed Development	☐ Cystic Fibrosis	☐ TMJ Problems	☐ Chemo/Radiation Therapy
☐ Brain Injury	☐ Muscular Disorder	☐ Cancer/ Malignancy	☐ Sensory Issues	☐ Emotional/Behavioral Issues
☐ Acid Reflux	☐ Depression/Anxiety	☐ Tobacco Use	☐ Pregnancy	☐ Hearing/Visual Impaired
☐ Special Needs	☐ Thyroid Disorder	☐ Gag Reflex	☐ HIV/ AIDS	☐ Heart Murmur/Defect/Surgery
☐ Cleft Lip/ Palate	☐ Stomach/GI Disorder	☐ Eating Disorder	☐ Hearing/Vision Problems	

Other: ______________________________ If yes to any of the above, please detail. ____________________

____



Authorization & Release

To the best of my knowledge, I have accurately answered the questions on this form. I understand that providing incorrect information can be dangerous to the patients' health. It is my responsibility to inform the dental office of any changes in the patients' medical status. I also authorize the dental staff to perform all necessary dental services the patient may need, including guidelines outlined by the AAPD for routine radiographs. I understand that Mercer Children's 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 specialist. 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 Mercer Children's 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.

______________________________ ______________ ______________

Signature of Responsible Party   Relationship to child   Date

Dentist's Review: ____

____

____ ______________

Signature of Dentist   Date