PEDIATRIC FORM

Welcome to our office! Please fill in all pertinent blanks on the form. Accurate answers to these questions will allow us and your insurance company to better serve you. If you have any difficulty completing this form, please feel free to ask the receptionist to assist you. If you would like for us to file for your dental insurance benefits, please present any insurance forms that you might have to the receptionist, signed with sections for the patient and employee information completely filled out.

ABOUT YOUR CHILD

Child's Name: ____ Nickname: _____________________ Date: ________________________

Name of School: ____ Grade Level: ___________________ Age: _________________________

Birthdate: ______/_______/_________ Child's Social Security: _______-_______-__________ Child's Home #: (______)_______-__________

Child's Home Address: ____ City: _______________________ State: _______ Zip: ___________

Referred By: ____

INSURANCE INFORMATION

Company Name: ____ Insured's Name: ____

Insured's ID: ______________________ Group #: _______________________ Birthdate: _____/_____/_______ Relation: ______________

Home Address: ____ City: __________________________ State: _______ Zip: ____________

Insured's Employer: ____ Does policy cover Orthodontics? ☐ YES ☐ NO

SECONDARY INSURANCE INFORMATION (if applicable)

Company Name: ____ Insured's Name: ____

Insured's ID: ______________________ Group #: _______________________ Birthdate: _____/_____/_______ Relation: ______________

Home Address: ____ City: __________________________ State: _______ Zip: ____________

Insured's Employer: ____ Does policy cover Orthodontics? ☐ YES ☐ NO

CHILD'S FAMILY INFORMATION

Who is accompanying this child today? (Full Name): ____ Relation to child: ________________

Do you have Legal Custody of this child? ☐ YES ☐ NO How many siblings? _________________ Their ages: ______________________

Mother's Name: _______________________________ ☐ Mom ☐ Step Mother ☐ Guardian Birthdate: ______/_______/_______

Home Address: ____ City: __________________________ State: _______ Zip: ____________

Home #: (_______)________-____________ Cell #: (_______)________-_____________ Work #: (_______)________-________ ext_______

Employer: ____ How Long?: _______ Present Position: ____________________________

Employer's Address: _______________________________________ City: ____________________________ State: _______ Zip: ____________

Mother's Social Security: _______-_______-__________ Mother's Driver's License #: _____________________________ State: __________

Father's Name: _________________________________ ☐ Dad ☐ Step Father ☐ Guardian Birthdate: ______/_______/_______

Home Address: ____ City: __________________________ State: _______ Zip: ____________

Home #: (_______)________-____________ Cell #: (_______)________-_____________ Work #: (_______)________-________ ext_______

Employer: ____ How Long?: _______ Present Position: ____________________________

Employer's Address: _______________________________________ City: ____________________________ State: _______ Zip: ____________

Father's Social Security: _______-_______-__________ Father's Driver's License #: _____________________________ State: __________

ACCOUNT INFORMATION (Person ultimately responsible for account)

Name: ____ Relation to child: _______________ Driver's License #: ______________

Billing Address: ______________________________________ City: ___________________________ State: _______ Zip: ___________

Birthdate: _______/_______/_________ Cell #: (_______)________-_____________ Work #: (_______)________-________ ext_______

Payment Method: __________________ ☐ Cash ☐ Check ☐ Credit Card Card #: _________________________ Exp: ____/_______

Initials: ________ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

CHILD'S DENTAL INFORMATION

Reason for today's visit: _________________________________ ☐ Exam ☐ Emergency ☐ Consultation Is Child in pain? ☐ YES ☐ NO

Please indicate any of the following problems:

☐ Bad Breathe ☐ Blisters/Sores in or around the mouth ☐ Broken/Chipped tooth
☐ Discomfort, clicking or popping in jaw ☐ Loose tooth ☐ Lost/Broken Filling(s)
☐ Locking jaw ☐ Red, swollen or bleeding gums ☐ Ringing in Ears
☐ Sensitive tooth, teeth or gums ☐ Stained teeth ☐ Teeth Grinding
☐ Other(s): ____

Does Child require pre-medication: ☐ YES ☐ NO Name of Previous Dentist: ____________________________________

CHILD'S MEDICAL HISTORY

Is Child taking any of the following medications: ☐ Pain Killers (including aspirin) ☐ Tranquilizations ☐ Stimulants ☐ Blood Thinners ☐ Ritalin ☐ Insulin ☐ Muscle Relaxers ☐ Others: ____________________

If Child has ever taken the drug Ritalin, when: _______/_______/_________ how long: ____________________

Child's Physician: ______________________________________ Last Medical Exam: _______/_______/_________

Business Address: ______________________________________ City: ___________________________ State: _______ Zip: ___________

Does Child have or ever had any of the following diseases, medical conditions or procedures:

Y	N		Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Congenital Heart Defect	☐	☐	Jaw Problems TMJ/TMD
☐	☐	Artificial Bones/Joints/Implants	☐	☐	Diabetes/Hypoglycemia	☐	☐	Leukemia/Anemia
☐	☐	Artificial Heart Valves	☐	☐	Fainting/Seizures/Epilepsy	☐	☐	Liver/Kidney/Organ Problems
☐	☐	Asthma/Difficulty Breathing	☐	☐	Hearing Problems	☐	☐	Psychiatric Problems
☐	☐	Birth Defects	☐	☐	Heart Murmur	☐	☐	Respiratory Problems
☐	☐	Blood Transfusion(s)	☐	☐	Hemophilia	☐	☐	Rheumatic Fever
☐	☐	Cancer/Tumors	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Cerebral Palsy	☐	☐	High/Low Blood Pressure	☐	☐	Surgeries/Operations
☐	☐	Cleft Lip/Palate	☐	☐	HIV+/AIDS/ARC	☐	☐	Tonsillitis
☐	☐	Chemotherapy	☐	☐	Hyper Active/ADD	☐	☐	Tuberculosis TB

Please list any medical condition(s) child has ever had: ____

Is Child allergic to: ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Dental Anesthetics (Novocain) ☐ Aspirin ☐ Food Allergies ☐ Other(s): _________________________________

Please rate the child's general health from 1 – 10: _____________ Does child wear contact lenses: ☐ YES ☐ NO Blood type: __________

Does Child do any of the following: ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking ☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting ☐ Other: _________________________

- We invite you to discuss with us any questions regarding our services. The best Dental Health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient signature: ____ Date: ________________________

Parent or Guardian: ____ Date: ________________________

UPDATE
(Office Use)

______ ____/_____/______
Initials Date

____
Comments

______ ____/_____/______
Initials Date

____
Comments

______ ____/_____/______
Initials Date

____
Comments