Greenhaven Pediatric dentistry

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Tell Us About Your Child

Child's Name: _____ Nickname: _____
Last *First* *MI*

Child's Birthdate: _____ Child's Age: _____ Gender: _____

School: _____ Grade: _____

Child's Home Address: _____
Street *City* *State* *Zip*

What is the primary reason for today's visit? _____

How did you hear about us? (Check the box that applies)

☐ Drive-by/Walk-in ☐ Google/Search ☐ Insurance Directory ☐ Social Media
☐ Review Website ☐ Other

☐ Referred by patient? If so, please list their name: _____

☐ Referred by Pediatrician or dentist? If so, please list their name: _____

Dental History

Is this your child's first dental visit? ☐ Yes ☐ No

Is your child currently in pain? ☐ Yes ☐ No Has your child experienced problems with previous dental treatment? ☐ Yes ☐ No

If so, explain: _____

Previous dentist: _____ Date of last visit: _____ Date of last x-ray: _____

Why did you leave your previous dentist? _____

Have there been any injuries to your child's teeth or jaws? ☐ Yes ☐ No

Does your child take fluoride vitamins or drink fluoridated water? ☐ Yes ☐ No

Has your child been seen by an orthodontist? ☐ Yes ☐ No Who? _____

Does / did your child have any of the following habits: *(check the boxes that apply)*

☐ Breast fed ☐ Jaw pain ☐ Nursing bottle habits ☐ Thumb / finger sucking
☐ Chewing on objects ☐ Lip sucking / nail biting ☐ Pacifier ☐ Tongue / cheek biting
☐ Clenching / grinding teeth ☐ Mouth breather ☐ Sippy cup ☐ Tongue thrust

Medical History

Child's physician: _____ Phone: _____ Date of last visit: _____

Is your child currently under the care of a physician ☐ Yes ☐ No Please explain: _____

Does your child have social / personality / temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are immunizations current?** ☐ Yes ☐ No

Please list all medication and dosage that your child is currently taking: _____

Please list all drugs and / or things that cause your child allergic reactions: _____

Anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Has your child had / experienced any of the following: *(check the boxes that apply)*

☐ Abnormal bleeding ☐ Breathing / Lung problems ☐ Frequent infections ☐ Mental delays
☐ ADD / ADHD ☐ Cancer / Tumors ☐ Heart condition / Murmur ☐ Physical delays
☐ AIDS / HIV + ☐ Celiac disease ☐ Hearing Problems ☐ Rheumatic fever
☐ Anemia ☐ Cerebral palsy ☐ Hepatitis ☐ Sight disorders
☐ Any hospital stays ☐ Congenital birth defect ☐ High blood pressure ☐ Social delays
☐ Any operations ☐ Diabetes ☐ Kidney disease ☐ Speech Delay
☐ Asthma ☐ Endocrine system disorders ☐ Liver disease ☐ Stomach / GI disease
☐ Autism ☐ Epilepsy / Seizures ☐ Low blood pressure ☐ Tuberculosis (TB)
☐ Blood disorder ☐ Frequent headaches ☐ Lupus

Please discuss any serious medical problems your child experiences, now or in the past: _____

Supplemental Questions for Ages 12+:

Has your child experienced puberty? ☐ Yes ☐ No

Is your child pregnant or nursing? ☐ Yes ☐ No

Is your child on birth control? ☐ Yes ☐ No

Legal Guardian's Information

Legal Guardian #1 Email: _____

Name: _____ Birthdate: _____ Relationship to Child: _____

Cell Phone: _____ Alt Phone: _____ Social Security #: _____

Legal Guardian #2 Email: _____

Name: _____ Birthdate: _____ Relationship to Child: _____

Cell Phone: _____ Alt Phone: _____ Social Security #: _____

Emergency Contact: _____ Address: _____ Phone: _____

Insurance Information

Is your child covered by a dental insurance plan? ☐ Yes ☐ No

Primary Insurance

Insurance Co. Name: _____ Phone #: _____ Group #: _____

Street / PO Box *Plan, Local, or Policy Number*

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Birthdate: _____ Subscriber's ID #: _____ Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone #: _____ Group #: _____

Street / PO Box *Plan, Local, or Policy Number*

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Birthdate: _____ Subscriber's ID #: _____ Employer: _____

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payers and / or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

Signature _____ Date _____

Acknowledgement of Receipt of Dental Materials Fact Sheet

I have received from Greenhaven Pediatric Dentistry a copy of the Dental Materials Fact Sheet dated May 2004.

Signature _____ Date _____

Consent for Dental Treatment

I request and authorize Dr. Ho and her staff to provide my child with a comprehensive examination and prescribe X-rays that may be considered necessary to diagnose and/or treat my child's dental condition. Thereafter, I will be presented the treatment recommendations, risks, benefits and options to make informed decisions about my child's care. At that time I request and authorize Dr. Ho and her staff to complete the accepted treatment for my child.

Signature _____ Date _____

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian. Initials _____ Date _____