

PEDIATRIC DENTAL SPECIALISTS, P.C.

Welcome!

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

ABOUT YOUR CHILD

Today's Date _____

Name: _____
FIRST MI LAST

Sex: M F Age: _____ Birthdate: _____ / _____ / _____

Address: _____
APT/CONDO#

CITY STATE ZIP

Home # _____

Family Email: _____

MORE ABOUT YOUR CHILD

Do you have legal custody of this child? Yes No

Is your child adopted? Yes No

Who may we thank for referring you to our office?

Previous Dentist & Phone # _____

Date of Last Visit _____

Other family members seen by us? _____

PRIMARY DENTAL INSURANCE

Ins. Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____ / _____ / _____

Insured's Employer: _____

I authorize my insurance company to pay directly to dentist:

Signature: _____

ACCOUNT INFORMATION

Parent's Name: _____
FIRST MI LAST

Parent's SS# _____

Work # _____ Ext. _____ Home # _____

Cell # _____ D.L. # _____

Occupation: _____

Employer: _____

Parent's Name: _____
FIRST MI LAST

Parent's SS# _____

Work # _____ Ext. _____ Home # _____

Cell # _____ D.L. # _____

Occupation: _____

Employer: _____

Marital Status: Married Single Divorced Separated Other

OTHER

Person Responsible for Account

Name: _____ Relationship to child: _____
Billing Address if different from child's:

ADDRESS _____

CITY STATE ZIP

SECONDARY DENTAL INSURANCE

Ins. Co. Name: _____

Ins. Co. Phone #: _____

Group # (Plan, Local or Policy #) _____

Insured's Name: _____

Relationship to Patient: _____

Insured's Birthdate: _____ / _____ / _____

I authorize my insurance company to pay directly to the dentist.

Signature: _____

DENTAL HISTORY

Why did you bring your child to the dentist today?

- Has your child ever had dental problems or previous dental treatment? YES NO
- Has your child ever had any pain/tenderness in their jaw (TMJ/TMD)? YES NO
- Does your child brush daily? YES NO
- Floss their teeth daily? YES NO
- Does your child have any of the following habits?
 - Finger/Pacifier habit YES NO
 - Bottle/sippy cup habits YES NO
 - Breast Feeding YES NO
 - Lip Sucking/biting YES NO
 - Nail biting YES NO

Emergency Contact Name & Telephone Number:

Relationship to patient _____

MEDICAL HISTORY

Has your child had problems with any of the following?

- | | |
|---------------------------------------|------------------------|
| Y N Allergies | Y N Cancer |
| Y N Latex Allergy | Y N Kidney |
| Y N Asthma/RAD | Y N Hepatitis /Liver |
| Y N Heart Murmur/Defect | Y N HIV+/AIDS |
| Y N Diabetes | Y N GERD |
| Y N Developmental Disability | Y N Anorexia/Bulimia |
| Y N Autism/ASD | Y N Hearing Impairment |
| Y N ADD/ADHD | Y N Shunts/Implants/ |
| Y N Seizures/Epilepsy | |
| Y N Bleeding Disorder | |
| Y N Operations/Hospitalizations _____ | |
| Y N Syndrome _____ | |
| Y N Other _____ | |

*Please discuss those things marked yes, as well as any other serious medical problems your child has had:

Please list all prescription and over the counter medications your child is *currently taking* and for what condition:

Please list all drugs your child is *allergic* to and type of reaction: _____

Child's Physician _____ Phone # _____ Date of last visit _____

Is your child currently under the care of a physician? YES NO

Your child's current physical health is: GOOD FAIR POOR

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

I acknowledge the information that I have given is complete and correct to the best of my knowledge, it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature: _____ Relationship to child: _____ Date: _____

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible.
If you have any questions, please feel free to ask us at any time.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian & patient named herein.

Initials: _____ Date: _____ Doctors Comments _____

JOSEPH C CREECH JR, DDS
BRADFORD J BALL DDS

KIMBERLY L SHERRILL, DDS
CHARLES E CLARK, DMD