MIDDLETOWN

PEDIATRIC DENTAL

PATIENT INFORMATION

Today's Date: ____/____/____
Child's Name: _____
Birthdate: ____/____/____ Child's Age: _____
Nickname: _____ ☐ Male ☐ Female
Child's Home #: _____
Child's Home Address:_____
City: _____ State: _____ Zip: _____
Grade: _____ School: _____
Hobbies: _____

ACCOMPANYING GUARDIAN

Name: _____
Relationship to patient: _____
Do you have legal custody of this child? ☐ YES ☐ NO
Whom may we thank for referring you? _____
_____
Other siblings seen by us: _____
Previous dentist: _____
Last visit date: _____
X-rays taken? ☐ YES ☐ NO

PARENTAL INFORMATION

☐ Mother ☐ Stepmother ☐ Guardian

Name: _____
Birthdate: ___/___/___ Home #: _____
Work #: _____ Cell #: _____
SS #: _____
Occupation: _____
Email: _____

☐ Father ☐ Stepfather ☐ Guardian

Name: _____
Birthdate: ___/___/___ Home #: _____
Work #: _____ Cell #: _____
SS #: _____
Occupation: _____
Email: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

PRIMARY DENTAL INSURANCE

Subscriber's Name: _____
Relationship to patient: _____
Subscriber ID #: _____ Subscriber DOB: ___/___/___
Insurance company_____ Phone: _____
Insurance company address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Group Name: _____ Group #: _____

SECONDARY DENTAL INSURANCE

Subscriber's Name: _____
Relationship to patient: _____
Subscriber ID #: _____ Subscriber DOB: ___/___/___
Insurance company_____ Phone: _____
Insurance company address: _____
City: _____ State: _____ Zip: _____
Employer: _____
Group Name: _____ Group #: _____

I certify that my child is covered by the above insurance company and I assign directly to Middletown Pediatric Dental all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian: _____ Date: _____/_____/_____

DENTAL HISTORY

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

_____

Has your child ever had a serious/difficult problem associated with previous dental work? ☐ YES ☐ NO

If yes, please explain: _____

_____

If your child's water fluoridated? ☐ YES ☐ NO

If your child taking fluoride supplements? ☐ YES ☐ NO

Does your child brush his/her teeth daily? ☐ YES ☐ NO

How often? ☐ 0-1 ☐ 1-2 ☐ 2+

Floss his/her teeth daily? ☐ YES ☐ NO

Has your child ever injured mouth/teeth? ☐ YES ☐ NO

If yes, please explain: _____

_____

Does/did your child have any of the following habits?

Nursing Bottle habits ☐ YES ☐ NO

Was the child breastfed? ☐ YES ☐ NO

Thumb/finger sucking ☐ YES ☐ NO

Nail Biting ☐ YES ☐ NO

Lip sucking/biting ☐ YES ☐ NO

Is there anything you would like to discuss with the doctor in private? ☐ YES ☐ NO

If yes, please explain:_____

_____

DELEGATION OF POWER by PARENT/GUARDIAN

Only if applicable

I give my consent to allow person(s) named below other than myself to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services. I understand I can revoke consent at any time by providing written notice.

Persons who have my consent in my absence are:

(1) _____

(2) _____

MEDICAL HISTORY

Child's Physician: _____

Phone#: _____ Date of Last visit: ___/___/___

Please describe child's current physical health:

☐ Good ☐ Fair ☐ Poor

Are the child's immunizations current? ☐ YES ☐ NO

Please list any current medications that your child it taking:

_____

_____

Aside from the things listed below, please list anything the child is allergic to, including medications: _____

_____

Latex: ☐ Y ☐ N Metals/Nickels: ☐ Y ☐ N Plastics: ☐ Y ☐ N

Has the child ever had any of the following medical issues?

☐ Y ☐ N Abnormal bleeding
☐ Y ☐ N ADD/ADHD
☐ Y ☐ N Anemia
☐ Y ☐ N Any hospital stays
☐ Y ☐ N Any operations
☐ Y ☐ N Artificial joints/valves
☐ Y ☐ N Asthma
☐ Y ☐ N Autism/Aspergers/PDD
☐ Y ☐ N Birth Defect
☐ Y ☐ N Cancer
☐ Y ☐ N Chicken Pox
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Convulsions
☐ Y ☐ N Developmental Delay
☐ Y ☐ N Diabetes
☐ Y ☐ N Epilepsy
☐ Y ☐ N Exposed to HIV but neg
☐ Y ☐ N Gastric Reflux
☐ Y ☐ N Headaches
☐ Y ☐ N Hearing Loss
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Hemophilia
☐ Y ☐ N Hepatitis
☐ Y ☐ N Hives
☐ Y ☐ N HIV+/AIDS
☐ Y ☐ N Kidney Disease
☐ Y ☐ N Liver Disease
☐ Y ☐ N Measles
☐ Y ☐ N Mononucleosis
☐ Y ☐ N Sensory Issues
☐ Y ☐ N Sickle Cell
☐ Y ☐ N Skin Rash
☐ Y ☐ N Thyroid Disease
☐ Y ☐ N Tuberculosis(TB)
☐ Y ☐ N Vision Loss
☐ Y ☐ N Other

Please list any serious medical problems your child has had:

_____

_____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform Middletown Pediatric Dental of any changes in my child's medical status or dental health. I authorize the dental staff to perform the necessary services my child may need.

Signature of Parent/Guardian: _____ Date: _____/_____/_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVARY PRACTICES

You may refuse to sign this acknowledgement

I ,_____have received a copy of this office's Notice of Privacy Practices.

Signature of Parent/Guardian: _____Date: _____/_____/_____

___Individual refused to sign