

# Pediatric Dentistry Associates

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www.JustKidsDentists.com



## MEDICAL HISTORY

1. Circle any of the following which your child now has or has had:

- |                          |                          |                            |
|--------------------------|--------------------------|----------------------------|
| Respiratory Problems     | Bruise Easily            | Limited Movement           |
| Blood Transfusions       | HIV Infection            | Cold Sores                 |
| Cystic Fibrosis          | Blood Disease            | Fever Blisters             |
| Sickle Cell Disease      | Excessive Bleeding       | Epilepsy                   |
| Kidney Disease           | Scarlet Fever            | Seizures                   |
| Motion Sickness          | Pneumonia                | Loss of Consciousness      |
| Cleft Lip/Cleft Palate   | Bronchitis               | Fainting or Dizzy Spells   |
| Latex Allergy            | Liver Disease            | Trauma to Head             |
| Radiation Treatment      | Tuberculosis             | Cerebral Palsy             |
| Heart Failure            | Asthma                   | Attention Deficit Disorder |
| Heart Disease            | Hay Fever                | Developmentally Delayed    |
| Heart Murmur             | Sinus Trouble            | Autism                     |
| Heart Surgery            | Allergies or Hives       | Mental Impairment          |
| Artificial Heart Valve   | Diabetes                 | Nervousness                |
| Congenital Heart Disease | Glandular Problems       | Psychiatric Treatment      |
| High Blood Pressure      | Cancer Treatment         | Hearing Impairment         |
| Rheumatic Fever          | Hepatitis A (infectious) | Vision Impairment          |
| Scarlet Fever            | Hepatitis B (serum)      | Ear Infections             |
| Anemia                   | Hepatitis non A/non B    | Rheumatoid Arthritis       |
| Hemophilia               | Veneral Disease          | Stomach Problems           |

Allergies or any unfavorable reaction to any medicine such as penicillin, aspirin, or local anesthetic?

List: \_\_\_\_\_

Does your child have any disease, condition or problem not listed? \_\_\_\_\_ Yes No

List: \_\_\_\_\_

2. Is your child taking any medications at this time? \_\_\_\_\_ Yes No

List: \_\_\_\_\_

3. Has your child ever had a serious illness or operation? \_\_\_\_\_ Yes No

List: \_\_\_\_\_

4. Has your child ever been hospitalized? \_\_\_\_\_ Yes No

For what? \_\_\_\_\_

5. Does your family have a history of complications from general anesthesia? \_\_\_\_\_ Yes No

If so, what type of complications? \_\_\_\_\_

6. Has your child had a physical exam within the last year? \_\_\_\_\_ Yes No

7. Child's physician or pediatrician \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there are ever any changes in health, I will inform the doctor at the next appointment without fail.

\_\_\_\_\_  
Signature of patient, parent or guardian

Date: \_\_\_\_\_

Child's Full Name (last name first) \_\_\_\_\_ Preferred Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  
 Birthday \_\_\_\_\_ Place of Birth \_\_\_\_\_ Attends what school? \_\_\_\_\_ Grade \_\_\_\_\_  
 Names & ages of brothers and sisters \_\_\_\_\_  
 Hobbies, sports, pets & other interests \_\_\_\_\_  
 Residence Address \_\_\_\_\_ Email Address \_\_\_\_\_  
 Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Cell \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_ Preferred method of appointment reminder:  Phone  Home  Work  Cell ]  Email  
 Father's/Guardian's Name \_\_\_\_\_ Mother's/Guardian's Name \_\_\_\_\_

**MEDICAL ALERT:**

# DENTAL HISTORY

1. Who is your family dentist? \_\_\_\_\_
2. Is this your child's first visit to the dentist? \_\_\_\_\_ Yes No
3. If not, when was your child last seen by a dentist? \_\_\_\_\_
4. Name of dentist \_\_\_\_\_
5. Any previous unfavorable dental experience? \_\_\_\_\_ Yes No
6. Has your child had a toothache recently? \_\_\_\_\_ Yes No
7. Has your child ever fallen and chipped or damaged any of his/her teeth? \_\_\_\_\_ Yes No
8. Is there a history of oral habits (thumb sucking, lip or nail biting)? \_\_\_\_\_ Yes No
9. Do you brush your child's teeth? \_\_\_\_\_ Yes No
10. Do you floss your child's teeth? \_\_\_\_\_ Yes No
11. At what age did your child stop bottle/breast feeding? \_\_\_\_\_

Father/Guardian	Last Name	First Name	Initial	Birthdate	Relationship to Patient	
Address		City	State		Zip	Residence Phone No.
Employment			How Long?	Employment Phone No.		Cell Phone No.
Occupation		Social Security #		Email Address		

  

Mother/Guardian	Last Name	First Name	Initial	Birthdate	Relationship to Patient	
Address		City	State		Zip	Residence Phone No.
Employment			How Long?	Employment Phone No.		Cell Phone No.
Occupation		Social Security #		Email Address		

  

Nearest Relative Not Living with You	Name			Relationship		
Address		City	State	Zip	Residence Phone No.	Cell Phone No.

# PAYMENT PLAN – PERSONAL & INSURANCE

Financial understanding is essential for all parties concerned. Thank you!  
 (please check)     Cash     Charge Card     Insurance     Medicaid     Other  
 I would be interested in learning about additional third party financial options.

Person responsible for payment of this account, (print) \_\_\_\_\_

Signature \_\_\_\_\_

DENTAL INSURANCE
PRIMARY CARRIER
INSURANCE COMPANY
EMPLOYEE
UNION OR LOCAL NO.
GROUP NO.
DATE EMPLOYED
EMPLOYEE SOCIAL SECURITY NO.

DENTAL INSURANCE
SECONDARY CARRIER
INSURANCE COMPANY
EMPLOYEE
UNION OR LOCAL NO.
GROUP NO.
DATE EMPLOYED
EMPLOYEE SOCIAL SECURITY NO.

# CONSENT FOR SERVICES

Families who carry dental insurance understand that all dental services furnished are charged directly to the parent/guardian and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render service on the assumption that our charges will be paid by an insurance company.

I understand that responsibility for payment for Dental Services provided in this office for my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1-1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I also agree that in case credit is extended my credit can be checked with the Credit Bureau of Idaho. To the best of my knowledge the information I have provided is true and accurate.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
 Signature of parent, guardian or responsible party.      Date \_\_\_\_\_      Relationship to patient \_\_\_\_\_