WELCOME

PARK DENTAL GROUP, LLC

CHILD PATIENT INFORMATION FORM

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

TELL US ABOUT YOUR CHILD

Today's Date ______________________

CHILD'S NAME ______________________
LAST FIRST MI

Nickname ______________ Male Female

Child's Birthday ___ /___ /___ Child's Age __________

School ______________ Grade __________

Child's Home # ______________ SS # __________

CHILD'S HOME ADDRESS

____
STREET APT/CONDO #

____
CITY STATE ZIP

Email Address ______________________

WHO IS ACCOMPANYING THE CHILD?

Name ______________ Relation __________

Do you have legal custody of this child? Yes No

Whom may we thank for referring you? __________

Other family members seen by us __________

Previous / Present Dentist __________

Date of Last Visit __________

PLEASE CIRCLE ONE

Parent's Marital Status Single Widowed Partnered Married Divorced Separated

PARENTS INFORMATION

Mother Step Mother Guardian

Name ______________________

Birthday ___ /___ /___ SS # __________

DL # ______________ Email Address __________

Cell # ______________ Home # __________

Employer ______________ Work # __________

Father Step Father Guardian

Name ______________________

Birthday ___ /___ /___ SS # __________

DL # ______________ Email Address __________

Cell # ______________ Home # __________

Employer ______________ Work # __________

PERSON RESPONSIBLE FOR ACCOUNT

Name ______________ Relation __________

Billing Address ______________________
STREET APT/CONDO #

____
CITY STATE ZIP

Home # ______________ Work # __________

Employer ______________________

DL # ______________ SS # __________

WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name ______________________

Home # ______________ Work # __________

DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insurance Co. Name ______________________

Address ______________________

Phone # ______________________

Group # (Plan, Local or Policy #) __________

POLICY OWNER'S NAME __________

Relationship to Patient __________

Policy Owner's Birthday ___ /___ /___ ID # __________

Policy Owner's Employer __________

Orthodontic Coverage? Yes No

SECONDARY DENTAL INSURANCE

Insurance Co. Name ______________________

Address ______________________

Phone # ______________________

Group # (Plan, Local or Policy #) __________

POLICY OWNER'S NAME __________

Relationship to Patient __________

Policy Owner's Birthday ___ /___ /___ ID # __________

Policy Owner's Employer __________

Orthodontic Coverage? Yes No

CHILD PATIENT INFORMATION FORM CONTINUED

REASON FOR TODAY'S VISIT

Why did you bring the child to the dentist today? ___________

____

Has the child ever had a serious/difficult problem associated with pervious dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TDM)? Yes No

Does the child brush his/her teeth daily Yes No

Does the child floss his/her teeth daily? Yes No

Child's Physician ___________________________

Phone #__________________ Date of Last Visit______________

Is the child currently under the care of a physician? Yes No

CURRENT PHYSICAL HEALTH IS Good Fair Poor

Has the child ever taken Phen-Fen?
(Also known as Redux or Pondimin) If so, when?______________________

Please list all prescription drugs/over the counter or herbal supplement drugs that the child is currently taking________

____

Aside from the items below, list all drugs/materials that the child is allergic to ___________________________

____

Y N Latex Y N Metals/Nickel Y N Plastic

MEDICAL HISTORY

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- Y N Abnormal Bleeding
- Y N ADD / ADHD
- Y N Any Hospital Stays
- Y N Any Operations
- Y N Artificial Bones / Joints
- Y N Asthma
- Y N Cancer
- Y N Congenital Heart Defect
- Y N Convulsions / Epilepsy
- Y N Diabetes
- Y N Handicaps / Disabilities
- Y N Hearing Impairment
- Y N Heart Murmur
- Y N Hemophilia
- Y N Hepatits
- Y N HIV+ / AIDS
- Y N Kidney / Liver Problems
- Y N Rheumatic / Scarlet Fever
- Y N Sickle Cell Disease / Traits
- Y N Tuberculosis (TB)

Please discuss any serious medical problems that the child has ___________________________________

____

When describing recommended treatments, do you prefer more or less detail? ___________________________

MEDICAL HISTORY (CONTINUED)

DOES / DID THE CHILD EXPERIENCE ANY OF THE FOLLOWING?

- Y N Lip Sucking / Biting
- Y N Speech Problems
- Y N Nail Biting
- Y N Thumb / Finger Sucking
- Y N Mouth Breather
- Y N Tongue Thrust
- Y N Nursing Bottle Habits
- Y N Clenching / Grinding Teeth

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

CONSENT FORM

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 this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian_____________________________ Date_____________

The parent or guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein. Initials __________ Date ________

Doctor's Comments ____

MEDICAL HISTORY UPDATE

I have read my medical history dated__________and confirmed that it states past and present medical conditions Signature_______________Date___________

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