Westerville PEDIATRIC DENTAL

Practice Limited to Pediatric & Adolescent Care

Child Information

Name: _____ Relationship: _____

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Referred By: _____

Physician's Name: _____ Physician's Phone: ( ) _____

Children in Household

Name _____ Relationship _____ Birth Date _____ Age _____

Name _____ Relationship _____ Birth Date _____ Age _____

Name _____ Relationship _____ Birth Date _____ Age _____

Name _____ Relationship _____ Birth Date _____ Age _____

Name _____ Relationship _____ Birth Date _____ Age _____

Responsible Party Information

Mother Name: _____ ☐ Single ☐ Married ☐ Divorced ☐ Other

Home #: ( ) _____ Cell #: ( ) _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ **Date of Birth:** _____

Employer: _____ Work Phone: ( ) _____

Occupation: _____ **Email:** _____

Father Name: _____ ☐ Single ☐ Married ☐ Divorced ☐ Other

Home #: ( ) _____ Cell #: ( ) _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ **Date of Birth:** _____

Employer: _____ Work Phone: ( ) _____

Occupation: _____ **Email:** _____

Emergency Information

Please list a local contact in an emergency (other than listed above).

Name: _____ Relation: _____

Home Phone: ( ) _____ Mobile: ( ) _____

Responsible Party Dental Insurance Information

Primary Subscriber Name: _____ Primary Responsible Party Employer: _____

Dental Insurance Company Name: _____

Phone: ( ) _____ Policy Number: _____ Group Number: _____

Secondary Subscriber Name: _____ Secondary Responsible Party Employer: _____

Dental Insurance Company Name: _____

Phone: ( ) _____ Policy Number: _____ Group Number: _____

As the responsible party, I hereby agree to provide payment for all services, regardless of insurance coverage.

Signature of Responsible Party: _____ Date: _____

Please Complete Other Side ▶▶▶

Patient Name: _____ DOB: _____

Medical / Dental History

Has your child had any of the following medical or dental conditions/problems? Please mark the appropriate answers and fill in the blanks.

Medical History

☐ Yes ☐ No ☐ ADD ☐ ADHD ☐ Autism

☐ Yes ☐ No Sensory Issues

_____

_____

_____

☐ Yes ☐ No Allergy to drugs

If Yes, List: _____

☐ Yes ☐ No Allergy to latex

☐ Yes ☐ No Anxiety

☐ Yes ☐ No Asthma

☐ Yes ☐ No Bleeding disorders of concerns

☐ Yes ☐ No Bone/Joint problems

☐ Yes ☐ No Cancer

☐ Yes ☐ No Depression

☐ Yes ☐ No Diabetes

☐ Yes ☐ No Disabilities/ Handicaps

If Yes, Explain: _____

☐ Yes ☐ No Eating Disorder

Please specify: _____

☐ Yes ☐ No Epilepsy/Convulsions

☐ Yes ☐ No Genetic disorders

If Yes, Explain: _____

☐ Yes ☐ No Hepatitis

☐ Yes ☐ No Heart murmur

☐ Yes ☐ No Heart problems

If Yes, List: _____

☐ Yes ☐ No Premedication for dental work

☐ Yes ☐ No Hearing problems

If Yes, Explain: _____

☐ Yes ☐ No Hemophilia

☐ Yes ☐ No HIV/Aids

☐ Yes ☐ No Hospitalizations

_____

If Yes, Explain:

☐ Yes ☐ No Surgeries

_____

If Yes Explain:

☐ Yes ☐ No Kidney/Liver problems

☐ Yes ☐ No Rheumatic fever

☐ Yes ☐ No Tuberculosis

☐ Yes ☐ No Vision problems

____ Glasses ____ Contacts

Other _____

If you answered yes to any of the above and would like to further explain, please provide additional information here:

_____

_____

Dental History

☐ Yes ☐ No Abscesses (gum boils)

☐ Yes ☐ No Bleeding gums

☐ Yes ☐ No Clenching or grinding habit

☐ Yes ☐ No Fluoridated water

☐ Yes ☐ No Fluoride rinses/ Supplements

☐ Yes ☐ No Frequent mouth sores

☐ Yes ☐ No Injuries to jaw or teeth

☐ Yes ☐ No Lip/tongue biting habit

☐ Yes ☐ No Teeth brushed daily

☐ Yes ☐ No Teeth flossed daily

☐ Yes ☐ No Thumb/finger sucking habit

☐ Yes ☐ No Toothaches

If Yes, Explain: _____

_____

☐ Yes ☐ No First visit to dentist (if no, date of last visit)

_____

☐ Yes ☐ No Problems associated with previous dental visits (list)

_____

_____

_____

Current medications (list) _____

_____

Other dental problems or conditions (specify) _____

_____

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

Signature of Parent or Guardian: _____ Date: _____