Let's get to know you!

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Today's Date_____

Child's Name_____

Nickname_____ Age_____ Date of Birth_____ Sex: ☐Male ☐Female

SS#_____ Attends what school_____ Grade_____

Names and ages of brothers and sisters_____

Father_____ SS#_____

Date of Birth_____ Home phone_____ Cell Phone_____

Residence_____ City_____ State_____ Zip_____

Employed by_____ Business Phone_____

Employer address_____

Mother_____ SS#_____

Date of Birth_____ Home phone_____ Cell Phone_____

Residence_____ City_____ State_____ Zip_____

Employed by_____ Business Phone_____

Employer address_____

Parents are: ☐Married ☐Single ☐Divorced - Child lives with: _____

Email Address of ☐Mother or ☐Father : _____

Who is responsible for making appointments? Name_____

**Please provide a friend or relative who can be contacted in case of emergency.*

Emergency Contact_____ Phone_____

Who referred you to this office?_____

We will be glad to process any insurance claim forms. However, your co-payment will be due at the time of service. Our office requires one of the following arrangements for payment of fee at time of service.

Please check your preference: ☐Cash ☐Personal check ☐Visa/Mastercard ☐Care Credit ☐Currently covered by Medicaid

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #(Plan, Local or policy #)_____

Insured name: _____

Relationship to patient: _____

Insured Date of Birth: _____

SS#_____

Insured's Employer: _____

Secondary Dental Insurance (if applicable)

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group #(Plan, Local or policy #)_____

Insured name: _____

Relationship to patient: _____

Insured Date of Birth: _____

SS#_____

Insured's Employer: _____

I authorize the release of any information regarding this claim. I acknowledge that Wilderness Station Pediatric Dentistry has presented and made available to me their "Notice of Privacy Practices" for protected health information (available on website or upon request). I authorize Wilderness Station Pediatric Dentistry to use and disclose my Protected Health Information for treatment, payment and healthcare operations.

Signature_____ Date _____

As a courtesy, we will complete your insurance claim forms at our cost. A written cost estimate is always given to you before the service is provided. Your deductible, co-payment, and non covered portions will be calculated and due at the time of service. If your insurance fails to pay our office, then you will be responsible for the balance. *Thank you.*

Specializing in dental care for infants, children and teens.

Child Health/Dental History Questions

Has the child had any history of, or conditions related to, any of the following? (if not listed, please explain):

☐ Anemia	☐ Cancer	☐ Growth Problems	☐ Liver Disease	☐ Psychiatric Treatment
☐ Asthma	☐ Cerebral Palsy	☐ Hearing Impairment	☐ Lung Disease	☐ Recurrent Headaches
☐ Attention Deficit	☐ Cleft Lip/Palate	☐ Heart /Heart Defect	☐ Mental Retardation	☐ Rheumatic fever
☐ Autism	☐ Diabetes	☐ Hemophilia	☐ MRSA	☐ Seizures
☐ Bladder/Kidney	☐ Eye Disorders	☐ Hepatitis	☐ Muscle Disorders	☐ Sickle Cell Anemia
☐ Bleeding Disorders	☐ Eating Disorder	☐ HIV +/AIDS	☐ Nose/Throat Disease	☐ Thyroid Disease
☐ Bones/Joints	☐ Fainting	☐ Latex Allergy	☐ Pregnancy (teen)	☐ Tuberculosis

Please explain:_____

_____

Please list the name and phone number of the child's physician:

Name of Physician_____ Phone_____

Address_____ City_____ State_____ Zip_____

What is the greatest concern you have regarding your child's teeth?_____

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? ..... 1. If yes, please list:_____	☐	☐
2. Is the child allergic to anything? i.e. medications, latex or food? ..... 2. If yes, please explain:_____	☐	☐
3. Has the child ever had a serious illness? If yes, when_____ Please describe_____ 3.	☐	☐
4. Does the child have a history of any other illnesses? If yes, please list _____ 4.	☐	☐
5. Is the child currently being treated for any illness? ..... 5.	☐	☐
6. Has the child ever been hospitalized? ..... 6.	☐	☐
7. Has the child ever had a complication to general anesthetic? ..... 7.	☐	☐
8. Does the child have any speech difficulties? ..... 8.	☐	☐
9. Has the child ever had a blood transfusion? ..... 9.	☐	☐
10. Is the child physically, mentally, or emotionally impaired? ..... 10.	☐	☐
11. Does the child experience excessive bleeding when cut? ..... 11.	☐	☐
12. Is this the child's first visit to the dentist? If not the first visit, when was the last dental visit?_____ 12.	☐	☐
13. Has the child ever had any negative dental or medical experiences? ..... 13.	☐	☐
14. Has the child ever had any dental radiographs (x-rays) exposed? ..... 14.	☐	☐
15. Has the child ever suffered any injuries to the mouth, head or teeth? ..... 15.	☐	☐
16. What type of water does your child drink? ☐ City Water ☐ Well Water ☐ Bottled Water ☐ Filtered Water		
17. Does the child take fluoride supplements? ..... 17.	☐	☐
18. Is fluoride toothpaste used? ..... 18.	☐	☐
19. How many times are the child's teeth brushed per day?_____ When are the teeth brushed?_____		
20. Has either parent had a lot of tooth decay? ..... 20.	☐	☐
21. Has the child had a recent toothache? ..... 21.	☐	☐
22. Does the child suck his/her thumb, fingers or pacifier? ..... 22.	☐	☐
23. At what age did the child stop bottle feeding?_____ Breast Feeding? Age_____		
24. Does the child ever fall asleep with their bottle or sippy cup? ..... 24.	☐	☐
25. Does the child participate in sports? If yes, please list:_____ 25.	☐	☐

As a minor child, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete treatment, including diagnostic radiographs. Protective restraints are used only when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. If my child ever has a change in his/her health, I will inform the doctor at the next appointment without fail. I will be responsible for the cost of this dental treatment. For specific procedures, further information will be provided.

Signature_____ **Relation to child**_____ **Date**_____

For office use only: ☐ Premedication ☐ Medical Alert ☐ Allergies Reviewed by:_____ Date_____