Pediatric Dentistry of Eastern Arkansas

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Welcome to our office! Please fill out this form completely in ink.

Child's name_______________________________Birthdate______________Sex M F
Name child goes by____
Child's Social Security #____
Hobbies/Pets____
Home Address_____________________________________Phone #__________
City__________________________ST________ZIP_________________ Grade
Names and ages of other children in family_______________________________
Do parents live together? Y N If not, with whom does the child live?____________

Parent/Guardian Information ____Mother____Stepmother____Guardian

Name______________________________DOB_________Occupation______________
Employer__________________________Work phone #________________________
SS#_______________________________Cell#________________________________
Marital Status M D W S Email address___________________________________

Parent/Guardian Information_____Father____Stepfather____Guardian

Name______________________________DOB_________Occupation______________
Employer__________________________Work phone#_________________________
SS#_______________________________Cell#________________________________
Marital Status MD W S Email address___________________________________
Who told you about our office?
Who is your family Dentist?

Method of payment

__check or cash, __BANK CARD, __VISA/MASTERCARD
__MEDICAID #_________________________________
__Insurance-plus copay/deductibe at time of treatment

Primary Dental Insurance

Insured's Name_____________________________________RELATIONSHIP__________
DOB____________________SS#____
EMPLOYER____
GROUP #__________________________PHONE #________________________________

Financial policy-Fees for dental services are due on the date of treatment. Our office, as a courtesy to you, will file for insurance benefits for treatment rendered. At your first visit we request that the balance be paid in full. On subsequent visits, you will be responsible for any deductibles, co-payments, or balances not covered by your insurance. All account balances which have not been paid within 30 days becomes the responsibility of the parent/guardian. There will be a $25.00 charge on all returned checks.

I,________________________have received a copy of this office's Privacy Practices.
__________________________ Patient name
INDIVIDUAL REFUSED TO SIGN

Child's Medical and Dental History

Name of child's pediatrician or physician____

Has your child been hospitalized since birth? Y N If yes, explain ____________________

____

Is your child allergic to any medicine or foods? Y N If yes, explain _________________

Is your child presently taking any medication? Y N If yes, please list ______________

____

Has your child ever had any of the following?

NO	YES		NO	YES	
___	___	Asthma	___	___	Ear infections/tubes
___	___	Anemia	___	___	Sinus trouble
___	___	Allergies	___	___	Thyroid
___	___	Hepatitis	___	___	Cystic Fibrosis
___	___	Abnormal Bleeding	___	___	Latex Allergy
___	___	Diabetes	___	___	Mental/Emotional Disorder
___	___	Handicap/Disabilities	___	___	ADD/ADHD/Hyperactivity
___	___	Tuberculosis	___	___	Blood Disease
___	___	Skin Disorder	___	___	Cancer/Tumor
___	___	Down Syndrome	___	___	Stomach/Kidney Problems
___	___	Rheumatic Fever	___	___	Liver Problems
___	___	Heart Condition	___	___	Seizures/Epilepsy
___	___	Pre-medication needed	___	___	HIV/AIDS
___	___	Lung Disorder	___	___	Speech
			___	___	OTHER

Please explain any medical problems that your child has:_____________________________

____

Is this your child's first visit to the dentist? Y N

If not, please give date of last dental care: __________Previous dentist_______________

Does your child have dental problem that you are especially concerned?_______________

____

Does your child take fluoride tablets, drops or vitamins with fluoride? Y N

Is your child on a bottle? Y N If no, what age was it discontinued? __________________

Does your child have **THUMB SUCKING, PACIFIER, OR FINGER HABIT**? Y N

Does your child brush teeth daily? Y N If not, how often?___________________________

Do you assist your child with flossing? Y N

Has your child bumped any teeth Y N If so, when? _________________________________

Has your child ever had a reaction to dental anesthetic? Y N

Authorization & release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental 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. I also authorize the dentist to release any information, including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of

Parent/Guardian________________________________Date_____________________