New Patient Welcome

Welcome to my practice! I strive to make each of your child's visits pleasant and comfortable.
My goal is to teach your child oral habits that will help keep their smile for a lifetime.

Child Name_____ Nickname_____
( ) Male ( ) Female Birthdate_____ Age_____
Child's Address_____ School_____
City_____ Zip Code_____ Grade_____
Siblings _____

Parents: ( ) Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Other_____
( ) Mother ( ) Stepmother ( ) Other _____ Address_____
Name _____ City _____ Zip Code _____
Social Security #_____ Birthdate _____
Home Phone_____ Work # _____
Cell Phone _____ Email _____
Employer_____ Occupation_____

( ) Father ( ) Stepfather ( ) Other _____ Address_____
Name _____ City _____ Zip Code _____
Social Security #_____ Birthdate _____
Home Phone_____ Work # _____
Cell Phone _____ Email _____
Employer_____ Occupation_____

**It is the responsibility of the family to know their own insurance plan benefits and coverage details. Please inform us of any changes at the time of appointment. As a courtesy we will bill your primary insurance company, although they may pay less than the actual bill for services. If your insurance carrier does not remit payment within 30 days, the balance will be due in full from you. If the insurance company pays more than the estimated portion, we will promptly refund the credit amount to you. Please note that the parent bringing the child for dental services is legally responsible for all fees.

Primary Dental Insurance
Insured's Name_____ Relationship_____
Social Security #_____ Birthdate_____
Identification # _____ Employer _____
Insurance Company_____ Group #_____
Insurance Address_____ Insurance Phone #_____

Secondary Dental Insurance (We can only submit to those we are in contract)
Insured's Name_____ Relationship_____
Social Security #_____ Birthdate_____
Identification # _____ Employer _____
Insurance Company_____ Group #_____
Insurance Address_____ Insurance Phone #_____

Authorization and Release:
To the best of my knowledge, the questions on this form have been accurately answered. I authorize consent for treatment. I authorize to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners.

Signature_____Date_____
* Hilliard Pediatric Dentistry follows HIPAA guidelines. Please let us know if you would like to obtain a copy

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Childs Name_____

Health History

Your child's overall health as well as any medications your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Child's Physician_____ Office or Practice Name _____

Physician's Phone_____ Date of last visit_____

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

If yes, for what condition?_____

Please list any medications your child is taking _____

For what condition?_____

Has your child had any allergic or unfavorable reaction to any medications? Yes ( ) No ( )

To What_____Reaction_____

If child is allergic to an antibiotic... What alternate antibiotic can your child take? _____

Other allergies? _____

Has your child ever been hospitalized? Yes ( ) No ( ) Reason_____

Has your child been treated in the emergency room: Yes ( ) No ( ) Any significant injuries? Yes ( ) No ( )

Age_____Reason_____

Are your child's immunizations up-to-date? Yes ( ) No ( )

Please explain any medical conditions that your child has _____

_____

Has your child ever had any of the following: (Check box if yes)

( ) Asthma, breathing/Lung Problems ( ) Cancer/Tumors ( ) Heart Defects

( ) Liver Disorder/Hepatitis ( ) Frequent Headaches ( ) HIV/AIDS ( ) Seizures/Epilepsy ( ) Frequent Infections ( ) Blood/Clotting Disorders ( ) Blood Tranfusions ( ) Kidney Problems ( ) Endocrine/Growth Problems ( ) Physical/Mental Disabilities ( ) Hearing Problems ( ) Bone/Joint Disorders ( ) Birth/Genetic Defects ( ) Vision Problems ( ) Autism

Dental History

How often does your child brush? _____ Floss? _____

Who is responsible for brushing the child's teeth _____

Date of last dental visit_____

Has your child had any of the following dental problems? (Check box if yes)

( ) Injuries to mouth or teeth ( ) Toothaches ( ) Abscesses

Other specify_____

What is the child's current drinking water supply?

_____City _____ Home (well) _____Bottled _____ Don't know

( ) Yes ( ) No ~Is this water fluoridated?

( ) Yes ( ) No ~Does your child receive fluoride tablets, drops or vitamins with fluoride?

( ) Yes ( ) No ~Does your child suck thumb/finger?

( ) Yes ( ) No ~Does your child suck/bite lips?

( ) Yes ( ) No ~Does your child bite/chew nails?

( ) Yes ( ) No ~Does your child chew hard objects (pencils, etc.)?

( ) Yes ( ) No ~Does your child grind teeth?

( ) Yes ( ) No ~Does your child clench jaws?

Is there any additional dental information we should know? _____

At what age was bottle or breastfeeding stopped? _____

Do you think the child will cooperate for dental treatment? ( ) Yes ( ) No

Has the child had a bad or fearful dental or medical experience? ( ) Yes ( ) No

Which of the following best describes the child?

( ) Advanced in the learning process ( ) Progressing normally ( ) slow learner

Does the child have any history of emotional or behavioral problems? ( ) Yes ( ) No

Dentist's Review/Notes _____