

Date

Patient’s Name Birth Date Age

Nickname Sex (Circle one) F M Other Patient’s Phone #

Address

 (Street) (City) (State) (Zip code)

Home Phone # ( ) Name & Ages of Siblings

Parent #1: Name (Mr., Mrs., Ms., Dr.) Social Security # DOB

Parent #1 Employer Work Ph. # ( ) Mobile ( )

Parent #2 Name (Mr., Mrs., Ms., Dr.) Social Security # DOB

Parent #2 Employer Work Ph. # ( ) Mobile ( )

Who has legal custody of patient? Patient lives with: Mother Father Both Other

**Please provide the email address(es) of those who would like to receive appointment confirmation emails:**

 Email Address: Mother Father Both Other

 Email Address: Mother Father Both Other

Pediatrician’s Name: Phone# ( ) Date of last exam

May we send an oral health update to your child’s physician? Yes No

Preferred Pharmacy Address Phone# ( )

**How did you hear about our office: Internet Search Website Facebook/Instagram Magazine Ad**

 **Physician or Dentist Parent in our practice Other**

**What is the reason for today’s visit?**

**Yes No Health History**

Has your child ever had a health problem? Please explain

 Has your child ever been hospitalized? Please give reason and dates Is your child allergic to anything? Is your child currently taking any medications? Please give medication and reason Were there any problems at birth? Will someone other than a legal guardian be bringing your child to their appointment?

Do you consider your child to be: Advanced Progressing Normally Delayed Other

**Please check if your child has been treated for any of the following:**

Acid Reflux Cancer Frequent Infections Light Sensitivity Speech Problems

 ADHD/ADD Canker Sores Growth Issues Learning Differences Stomach Issues

 AIDS/HIV Cold Sores Headaches Light Sensitivity Thyroid Disorder

 Anemia Cerebral Palsy Hearing Problems Liver Disease Ulcer

 Anxiety Cleft Lip/Palate Heart Disease Neurological Problems Vision Problems

 Asthma Cystic Fibrosis Heart Murmur Psychiatric Problems

 Autism Spectrum Depression Hepatitis A, B or C Respiratory

 Autoimmune Disorder Diabetes High Blood Pressure Seasonal Allergies

 Behavioral Issues Eating Disorder Joint Problems Sensory Disorder

 Bladder/Kidney Epilepsy/Seizures Latex Allergy Sickle Cell Bleeding/Transfusion Food Allergies Medication Allergies

**Adolescents:**  STD Substance Abuse, Alcoholism, Drug Addiction Pregnancy or Nursing Tobacco Use

 (Vaping/Smoking)

**Does your child have any disease, condition, syndrome or issue not listed here?**

**Yes No Dental History**

Has your child ever been seen by a dentist? Name of Dentist

 Date of Last Visit Dentist’s Phone # ( )

 Has your child experienced any unfavorable reaction from previous dental care? If yes, please explain. Does your child suck a: Thumb Finger(s) Pacifier Other

 Does your child snore during sleep or stop breathing during sleep?

 Has your child ever had problems with their jaw joint (TMJ)?

 Has your child had any recent injuries to the mouth or teeth?

 Is your child in any dental discomfort?

 How often does your child brush/floss?

 Has your child ever had Nitrous Oxide (Laughing Gas), if yes did they have an unfavorable reaction?

**Please check if your child is currently having problems with any of the following:**

 Cavities Toothache Sensitive Teeth Color of Teeth Trauma

 Gum Infection Crowded or Crooked Teeth Eruption Problems

 Pain with Chewing Grinding Teeth TMJ Pain

 Jaw or Joint Noise Other

**How cooperative do you feel your child will be for this appointment?**

 Well behaved Anxious Uncooperative Unsure Comments:

**Yes No** **Fluoride History**

Is your drinking water fluoridated? (Your water is fluoridated if you pay a water bill.)

 Do you use well water in your home? If yes, has it been analyzed for fluoride? Yes / No

 Does your child use a fluoride toothpaste?

 Do you give your child any other form of fluoride? What?

 **Consent of Dental Treatment**

I request and authorize River Road Pediatric Dentistry to examine, clean and provide dental treatment on my child’s teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the doctor examining my child to diagnose and/or treat my child’s dental problem. I will allow photographs to be taken of my child or child’s teeth for diagnostic & academic purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The dentists will provide an environment to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

Signature Relationship to Patient Date

**Payment Policy**

I will be responsible for any charges incurred on this child for dental treatment. I understand that by failing to make payments to River Road Pediatric Dentistry my account can be turned over to a collection agency. River Road Pediatric Dentistry will no longer provide dental care for my child 30 days after turn over. In cases of divorce, the custodial parent is responsible for any charges incurred.

Signature Relationship to Patient Date

 **Notice Of Privacy Practices**

I have been provided with River Road Pediatric Dentistry Notice of Privacy Practices that provides a complete description of their policy on the use of disclosure of protected health information.

Signature Relationship to Patient Date