lakeside

PEDIATRIC DENTISTRY

RYAN J HUGHES DDS MS

CHILD'S HISTORY

Child's Name _____ Nickname _____

(First) (Mi) (Last)

Date of Birth _____ Age _____ Gender _____ Place of birth _____

School _____ Grade _____

Explain briefly why you brought your child in for dental care _____

Whom may we thank for this referral? _____

Child's History – In order to render the best possible care and treatment for your child, your assistance is needed in answering the following questions.

1. When was your child's last visit to the dentist? _____ Were X-Rays Taken? _____
2. Prior Dentist Name? _____
3. Is your child receiving daily fluoride at the present time? _____ In what form? _____
4. Does your child have any habits such as pacifier, thumb sucking, etc? _____
5. Is there anything we should know about your child before beginning a dental examination? _____
6. Are there any questions you have regarding your child's dental development or care? _____

_____

7. Does your child have any health issues? _____ If so, what? _____
8. Tell us about any limiting behavioral, mental, or emotional issues _____

_____

9. What is the most serious illness your child has ever had? _____
10. Who is your child's physician? _____ Date of child's last physical examination? _____

Reason for last exam? _____ Are immunizations current? ☐ Yes ☐ No

11. Has your child ever been hospitalized? _____ When & why? _____
12. Does your child have or has your child ever had any of the following?

☐ Heart Trouble	☐ Allergies	☐ Diabetes	☐ HIV / Aids
☐ Asthma	☐ Epilepsy	☐ Tuberculosis	☐ Hepatitis
☐ Anemia	☐ Nervousness	☐ Rheumatic Fever	☐ Reflux
☐ Kidney Problems	☐ Liver Problems	☐ Bleeding Disorder	☐ Attention Deficit

13. Has your child ever experienced a negative reaction to medication such as penicillin, aspirin, or local anesthetic? _____

_____

14. Is your child on any medications now? _____ What? _____
15. Has your child had a negative reaction to medical or dental care? _____

CONSENT: The signature of the parent or guardian below authorizes the completion of all agreed upon dental services and the use of those methods and techniques appropriate thereto. This consent shall remain in full force and effect until cancelled by either party of behalf of:

Child's name _____

Parent or guardian signature _____ Rel. _____

Date _____

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GENERAL INFORMATION

Primary/Guardian 1 _____ SS# _____ DOB _____
(First) (Mi) (Last)
Street _____ State _____ Zip _____
Relationship to patient _____ Email _____
Primary Phone # _____ Cell # _____
Primary/Guardian 2 _____ SS# _____ DOB _____
(First) (Mi) (Last)
Street _____ State _____ Zip _____
Relationship to patient _____ Email _____
Primary Phone # _____ Cell # _____
With Whom Does the Child Live? _____
Who is the Custodial Parent? _____
Who is Responsible for This Account? _____
Driver's License # Father _____ Mother _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____
Insurance Co. Address & Phone # _____
Insured's Name _____
Insured's DOB _____
Insured's Employer _____
Insurance Effective Date _____
Group, Plan or Policy # _____
ID/SS# _____
Relationship to Patient _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____
Insurance Co. Address & Phone # _____
Insured's Name _____
Insured's DOB _____
Insured's Employer _____
Insurance Effective Date _____
Group, Plan or Policy # _____
ID/SS# _____
Relationship to Patient _____

IN CASE OF EMERGENCY

Name of a relative not living with you _____ Phone # _____
Relationship _____

PLEASE SIGN AND RETURN TO THE RECEPTIONIST

I have read the office financial policy. I authorize the dentist to bill my dental insurance and release information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

LIST ALL CHILDREN BELOW

1. Name _____ Sex _____ Age _____ Birth date _____
2. Name _____ Sex _____ Age _____ Birth date _____
3. Name _____ Sex _____ Age _____ Birth date _____
4. Name _____ Sex _____ Age _____ Birth date _____
5. Name _____ Sex _____ Age _____ Birth date _____
6. Name _____ Sex _____ Age _____ Birth date _____