Pleasant Mill Pediatric Dentistry

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

New Patient Information

Patient's Name_____ Nickname_____
Patient's DOB_____ Age_____ Weight_____ Sex ___M ___F Phone #_____
Patient's Home Address_____
City_____ State_____ Zip_____
Names and Ages of siblings in the family_____
With whom does the child reside?_____
Name of School_____ Grade_____

Mother's Information:

Name_____ DOB_____
Address_____ SS#_____
Email _____ Home #_____ Cell #_____
Employer_____ Work #_____

Father's Information:

Name_____ DOB_____
Address_____ SS#_____
Email _____ Home #_____ Cell #_____
Employer_____ Work #_____

Guardian's Information:

Name_____ DOB_____
Address_____ SS#_____
Email _____ Home #_____ Cell #_____
Employer_____ Work #_____

Dental Insurance:

Insured's Name_____ DOB_____
Relationship_____ SS#_____
Employer_____
Insurance Company Name_____ Group #_____
Insurance Company Phone #_____ Policy #_____

Whom may we thank for referring you to our office?_____

Consent for Dental Treatment

I request and authorize Pleasant Mill Pediatric Dentistry to examine, clean, apply fluoride, 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 Pleasant Mill Pediatric Dentistry to diagnose and/or treat my child's dental problem. I also authorize Pleasant Mill Pediatric Dentistry to release my child's records and/or x-rays to another dental office or specialist when deemed necessary. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational 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. Pleasant Mill Pediatric Dentistry will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I understand that my insurance provider may pay less than the actual bill for services. I will be responsible for any charges incurred on this child for dental treatment.

Signature_____ Date_____

Relationship to Patient_____

Pleasant Mill Pediatric Dentistry

Medical and Dental History

Patient Name_____ Patient DOB_____

Medical History:
Child's Physician_____ Practice Name_____
Date of Last Exam_____ Date of Last Immunizations_____

Yes No
( ) ( ) Is your child in good health?
( ) ( ) Is your child being followed by a physician for any reason? If yes, please explain_____
_____
( ) ( ) Has your child ever been hospitalized? If yes, please give date and reason_____
_____
( ) ( ) Is your child taking any medications? If yes, please list_____
_____
( ) ( ) Has your child had any unfavorable reactions to medications? If yes, please list_____
_____
( ) ( ) Does your child have any allergies? If yes, please list _____
_____

Do you consider your child to be
_____advanced in the learning process _____progressing normally _____slow in the learning process

Please check any of the following conditions for which the child has been treated for:

( )	ADD/ADHD	( )	DIABETES	( )	NERVOUS DISORDER
( )	ANEMIA	( )	DOWN SYNDROME	( )	NUTRITIONAL PROBLEM
( )	AIDS/HIV Positive	( )	EMOTIONAL PROBLEM	( )	PHYSICAL DELAYS
( )	ARTHRITIS	( )	EPILEPSY/SEIZURES	( )	RHEUMATIC FEVER
( )	ASTHMA	( )	HEART CONDITION/	( )	SEASONAL ALLERGIES
( )	ALLERGIES		MURMUR	( )	SENSORY DISORDER
( )	AUTISM	( )	HEARING DISORDER	( )	SPEECH DISORDER
( )	BLOOD DISORDER/ TRANSFUSION	( )	HEPATITIS	( )	TONSIL/ADENOID PROBLEMS
		( )	KIDNEY DISEASE		
( )	CANCER	( )	LIVER DISEASE	( )	TUBERCULOSIS
( )	CEREBRAL PALSY	( )	LUNG PROBLEMS	( )	VISION DISORDER
( )	CLEFT LIP/PALATE	( )	MENTAL DELAY/		
( )	CONGENITAL BIRTH DEFECTS		DISORDER		

Dental History:
Yes No
( ) ( ) Did the mother have any problems with the pregnancy? If so, please explain_____
_____
( ) ( ) Is this your child's first dental visit? If no, please give name and date of last visit_____
_____
( ) ( ) Will your child be uncooperative? If yes, please explain_____
_____
( ) ( ) Has your child experienced prolonged bleeding following dental treatment / surgeries? If yes, please explain_____
( ) ( ) Has your child had any injury to the teeth, jaws or face? If yes, please explain_____
_____

Was your child _____ breast fed? Age stopped _____ _____bottle fed? Age stopped_____
Did your child use a pacifier, have a finger or thumb habit? _____yes _____no Age stopped_____

Does your child - brush his/her own teeth? _____ use dental floss? _____ have bleeding gums? _____
Do you help your child brush? _____yes _____no
Have you ever received instructions in brushing? _____yes _____no

Is your home water supply fluoridated? _____city water _____well water
Does your child use any fluoridated products? _____toothpaste _____rinse _____drops _____tablets

To the best of my knowledge, the answers I have given are accurate. I understand it is important to report changes in my child's medical or dental status to the dentist and I agree to do so. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment.

Signature _____ Date_____
Relationship to Patient_____