



Pediatric Dentistry & Orthodontics

Welcome

Thank you for selecting our dental healthcare team!  
We will strive to provide you with the best possible dental care.  
To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

## Patient Information (CONFIDENTIAL)

Date \_\_\_\_\_

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Check Appropriate Box: ☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ ☐ Full Time ☐ Part Time

Patient Employer (if applicable) \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ May We Text You? ☐ Yes ☐ No

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Is this person accompanying the patient in our office today? ☐ Yes ☐ No (If No, who is?) \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

DO YOU HAVE ANY ADDITIONAL DENTAL INSURANCE? ☐ Yes ☐ No

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_

Address of Employer \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID # \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit \_\_\_\_\_

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Are your immunizations up to date?.....☐ Yes ☐ No

2. Are you under medical treatment now?.....☐ Yes ☐ No

3. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?.....☐ Yes ☐ No  
If yes, please explain \_\_\_\_\_

4. Are you taking any medication(s) including non-prescription medicine?.....☐ Yes ☐ No  
If yes, what medication(s) are you taking? \_\_\_\_\_

5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?.....☐ Yes ☐ No

6. Do you use tobacco?.....☐ Yes ☐ No

7. Do you use controlled substances?.....☐ Yes ☐ No

8. Do you have or have you had any of the following?

Genetic Syndrome.....☐ Yes ☐ No

High Blood Pressure.....☐ Yes ☐ No

Heart Attack.....☐ Yes ☐ No

Rheumatic Fever.....☐ Yes ☐ No

ADHD.....☐ Yes ☐ No

Fainting / Seizures.....☐ Yes ☐ No

Asthma.....☐ Yes ☐ No

Low Blood Pressure.....☐ Yes ☐ No

Epilepsy / Convulsions.....☐ Yes ☐ No

Leukemia.....☐ Yes ☐ No

Diabetes.....☐ Yes ☐ No

Kidney Diseases.....☐ Yes ☐ No

AIDS or HIV Infection.....☐ Yes ☐ No

Thyroid Problem.....☐ Yes ☐ No

Chicken Pox, Mumps, Measles.....☐ Yes ☐ No

Eating Disorders.....☐ Yes ☐ No

Heart Disease.....☐ Yes ☐ No

Autism.....☐ Yes ☐ No

Heart Murmur.....☐ Yes ☐ No

Angina.....☐ Yes ☐ No

Heart Surgery.....☐ Yes ☐ No

Anemia.....☐ Yes ☐ No

Emphysema.....☐ Yes ☐ No

Cancer.....☐ Yes ☐ No

Arthritis.....☐ Yes ☐ No

Joint Replacement or Implant.....☐ Yes ☐ No

Hepatitis / Jaundice.....☐ Yes ☐ No

Stomach Troubles / Ulcers.....☐ Yes ☐ No

Please elaborate if necessary: \_\_\_\_\_

9. Are you wearing contact lenses?.....☐ Yes ☐ No

10. Are you allergic to or have you had any reactions to the following?  
Local Anesthetics (e.g. Novocain).....☐ Yes ☐ No  
Penicillin or any other Antibiotics.....☐ Yes ☐ No  
Sulfa Drugs.....☐ Yes ☐ No  
Barbiturates.....☐ Yes ☐ No  
Sedatives.....☐ Yes ☐ No  
Iodine.....☐ Yes ☐ No  
Aspirin.....☐ Yes ☐ No  
Any Metals (e.g. nickel, mercury, etc.).....☐ Yes ☐ No  
Latex Rubber.....☐ Yes ☐ No  
Other (please list) \_\_\_\_\_

11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?...☐ Yes ☐ No

12. Women Only:  
a) Has menstruation started?.....☐ Yes ☐ No  
b) Are you pregnant or think you may be pregnant?.....☐ Yes ☐ No  
c) Are you nursing?.....☐ Yes ☐ No  
d) Are you taking oral contraceptives?.....☐ Yes ☐ No

Acid Reflux/Chronic Vomiting.....☐ Yes ☐ No  
Cleft Palate.....☐ Yes ☐ No  
Stroke.....☐ Yes ☐ No  
Hay Fever / Allergies.....☐ Yes ☐ No  
Tuberculosis.....☐ Yes ☐ No  
Radiation Therapy.....☐ Yes ☐ No  
Glaucoma.....☐ Yes ☐ No  
Recent Weight Loss.....☐ Yes ☐ No  
Liver Disease.....☐ Yes ☐ No  
Ear Infections/Tubes.....☐ Yes ☐ No  
Respiratory Problems.....☐ Yes ☐ No  
Mitral Valve Prolapse.....☐ Yes ☐ No  
Other.....☐ Yes ☐ No

# Patient Dental History

Name of Dentist \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

1. Have you ever had any trauma to the mouth?.....☐ Yes ☐ No

2. Do you feel pain to any of your teeth?.....☐ Yes ☐ No

3. Have you had any head, neck or jaw injuries?.....☐ Yes ☐ No

4. Have you ever experienced any of the following problems in your jaw?  
Clicking.....☐ Yes ☐ No  
Pain (joint, ear, side of face).....☐ Yes ☐ No  
Difficulty in opening or closing.....☐ Yes ☐ No  
Difficulty in chewing.....☐ Yes ☐ No

5. Do you have frequent headaches?.....☐ Yes ☐ No

6. Do you clench or grind your teeth?.....☐ Yes ☐ No

7. Do you bite your lips or cheeks frequently?.....☐ Yes ☐ No

8. Have you ever had any prolonged bleeding following extractions?.....☐ Yes ☐ No

9. Have you ever seen an orthodontist?.....☐ Yes ☐ No

10. Do you like your smile?.....☐ Yes ☐ No

11. Have you ever had a thumb or finger sucking habit?.....☐ Yes ☐ No

# Authorization and Release

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I request and authorize that Nelson Pediatric Dentistry & Orthodontics to provide necessary dental care for this child/patient. I authorize the use of diagnostic aids, medications, patient photos and procedures that are necessary in the professional judgement of Nelson Pediatric Dentistry & Orthodontics. I have read, understood, and agree to the terms outlined in the financial and treatment policy. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Finance charges may be incurred on past due balance.

X

Signature of patient (or parent/guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patterson #200098404