Parker-Gray
PEDIATRIC DENTAL CARE

## PATIENT INFORMATION

Patient Name:_____
Best contact number:_____ Best time of day to call _____
Email: _____
Is it ok to confirm appointments at the above E-mail? YES/NO Text Messages? YES/NO
Whom may we thank for referring you to our practice? _____

## FINANCIAL RESPONSIBILITY

Same as Above: Yes/No
Last Name:_____ First Name:_____ M.I._____
DOB:_____SS#:_____Employer:_____
Home Street Address:_____
City: _____ State: _____ Zip:_____
Home Number: _____Work Number:_____ Cell :_____
Email Address:_____

**Disclaimer: Payment is due in full at the time services are rendered. Cash, check, and most major credit cards accepted. The responsible party is ultimately responsible for any and all fees incurred. If dental insurance is filed, the estimated co-pay is due at the time services are rendered. The responsible party is further responsible for any amount that is discounted or disallowed by the insurance company, except in the case where the amount is a contractual discount. If the insurance does not remit payment within 60 days, the full balance becomes the obligation of the responsible party, and it is the responsible parties burden to collect from the insurance carrier. If an account should ever require collections action, the responsible party will be required to pay any and all collection fees.**
I understand and accept the above disclaimer as the responsible party.

Print Name:_____Signature:_____ Date:_____

## DENTAL INSURANCE INFORMATION

Dental Insurance Co.: _____Ph. #_____
Insurance Co. Address: _____
City State Zip
Policy Holder: _____ Relationship to Patient:_____
Policy Number: _____ Group Number: _____
Employer Name& Address_____
**Patient Acknowledgement and Acceptance:** I agree to pay according to the conditions and limitations of the policy at the time services are rendered. The signature below also constitutes my agreement as the insured or on behalf of the insured that they insurance company shall submit payment to Parker-Gray Pediatric Dental Care, PC. In the event that the insurance company incorrectly sends the check to me, I will be responsible to either sign over the check to Parker-Gray Pediatric Dental Care or directly pay the balance immediately.

**Patient Signature**_____ **Date**_____

# PATIENT INFORMATION AND HEALTH HISTORY

Today's date_____

Name_____

Date of Birth _____ Age _____ Male □ Female □

Home address _____

_____

Street City Zip code

**Yes / No** Are you in good health? Date of last medical checkup _____

Name of Physician _____ Phone _____

Preferred Pharmacy_____Phone_____

**Yes / No** Have you ever had any health problems? _____

_____

**Yes / No** Have you ever been hospitalized/Surgeries? If so, list why and date:

_____

**Yes / No** Are you currently taking any medication? If so, please list

_____

**Yes / No** Does you have any food allergies? Please list _____

**Yes / No** Are you allergic to any medications? _____

## Are you allergic to any of the following?

□ Acrylics □ Latex □ Codeine □ Metals □ Dyes

□ Jewelry □ Sulfa □ Dental Anesthetics **Other**_____

## Please check if you have a history of any of the following:

| | | | |
|---|---|---|---|
| □ **Hepatitis A** | □ **Blood Disorders** | □ **Cerebral Palsy** | □ **Congenital Birth Defect** |
| □ **Hepatitis B/C** | □ **Transfusions** | □ **Cleft Lip/Palate** | □ **Heart Defect (Congenital)** |
| □ **AIDS/HIV+** | □ **Bruise Easily** | □ **Development Delays** | □ **Heart Disease** |
| □ **Kidney disease** | □ **Hemophilia** | □ **Physical delays** | □ **Heart Valve (Artificial)** |
| □ **Liver disease** | □ **Sickle Cell Disease** | □ **Headaches** | □ **Thyroid** |
| □ **Diabetes** | □ **Arthritis** | □ **Epilepsy/Seizures** | □ **Cancer/ Chemo/Radiation** |
| □ **Hypertension** | □ **Asthma** | □ **Fever Blisters/Cold Sores** | □ **Eczema/Skin Problems** |
| □ **Cystic Fibrosis** | □ **Seasonal Allergies** | □ **Speech/Hearing Impaired** | □ **Visually Impaired (Glasses)** |
| □ **Anemia** | □ **Autism** | □ **Reflux disease(GERD)** | □ **Rheumatic/Scarlet Fever** |

**Please elaborate on ANY items marked**: _____

_____

_____

**Do you have any other concerns or is there anything else significant about your health history that you would like to mention?**_____

_____

# PATIENT DENTAL HISTORY

**What is your primary concern about your oral health?**

_____

**Yes / No** Have you ever been to the dentist? If yes, name of dentist and date

_____

**Yes / No** Have you had **dental x-rays** taken? If yes, approximate date_____
**Yes / No** Has you **had local anesthesia** (have your teeth numbed)?
**Yes / No** Have you experienced any unfavorable reaction from previous dental care? Please explain_____

**Yes / No** Is your home water supply fluoridated?
**Yes / No** Do you use toothpaste containing fluoride?
**How often do your brush your teeth? ____times per ____**
**How often do you floss your teeth?** □ Never □ Occasionally □ Daily

Does you have a history of any of the following? For each yes response, please describe.
**Yes/No** Inherited dental characteristics _____
**Yes/No** Mouth sores or fever blisters _____
**Yes/No** Bad breath_____
**Yes/No** Bleeding gums_____
**Yes/No** Cavities/decayed teeth_____
**Yes/No** Toothache_____
**Yes/No** Injury to teeth, mouth or jaws_____
**Yes/No** Clinching/grinding his/her teeth_____
**Yes/No** Jaw joint problems (popping, etc.)_____
**Yes/No** Excessive gagging_____

## Please check if you are currently having problems with any of the following:

□ Cavities □ Toothache □ Sensitive Teeth □ Trauma
□ Gum Infections □ Color of Teeth □ Orthodontics □ Jaw Sounds

**Is there anything else we should know before staring treatment:**_____
_____

_____
Signature of Patient Date