PARENT/GUARDIAN INFORMATION

Name of Father:____
Name of Mother:____
Name of Legal Guardian:____
Parent(s) Marital Status: Married______Single______Divorced______Other________
Who does the child live with?____
Whom is accompanying the child today?__________________________________
Whom should we contact about appointments? Mother___ Father____ Other_________
Best contact number:_______________________ Best time of day to call __________
Email: ___________________________
Is it ok to confirm appointments at the above E-mail? YES/NO Text message? YES/NO
Whom may we thank for referring you to our practice? _________________________________

FINANCIAL RESPONSIBLE PARTY
(INFORMATION OF PARENT/GUARDIAN PRESENT AND SIGNING THESE DOCUMENTS)

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.

Parent/Guardian Signature_________________________________ **Date**__________________

PATIENT INFORMATION AND HEALTH HISTORY

Today's date___________________

Child's Name______________________________ Child's Preferred Name_______________

Date of Birth _________________ Age _________ Male □ Female □

Home address ____

____

Street City Zip code

Yes / No Is your child in good health? Date of last medical checkup __________________

Name of child's Physician _______________________________ Phone __________________

Preferred Pharmacy______________________________________Phone__________________

Yes / No Were there any complications before or during birth? _______________________

Yes / No Has your child ever had any health problems? _____________________________

____

Yes / No Has your child ever been hospitalized/Surgeries? If so, list why and date:

____

Yes / No Is your child currently taking any medication? If so, please list

____

Yes/No Is your child up to date on immunizations against childhood diseases?

Yes / No Does your child have any food allergies? Please list ___________________________

Yes / No Is your child allergic to any medications? ___________________________________

Yes/No Has your child reached puberty?

Is your child allergic to any of the following?

□ Acrylics □ Latex □ Codeine □ Metals □ Dyes

□ Jewelry □ Sulfa □ Dental Anesthetics **Other**_____________

Please check if your child has 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**	□ **Frequent Infections**	□ **Epilepsy/Seizures**	□ **Cancer/ Chemo/Radiation**
□ **ADHD**	□ **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 child's health history that you would like to mention?_____________________________________

Patient Name: ____

What is your primary concern about your child's oral health?____

Yes / No Has your child ever been to the dentist? If yes, name of dentist and date

____

Yes / No Has your child had **dental x-rays** taken? If yes, approximate date_______________

Yes / No Has your child **had local anesthesia** (have they had their teeth numbed)?

Yes / No Has your child had nitrous oxide during a dental procedure?

Yes / No Has your child experienced any unfavorable reaction from previous dental care?

Please explain_ ____

Yes / No Does/Did your child suck a finger, thumb or pacifier? **Which one**: _______

What **age did they stop**? _________

Was your child: **Breast fed** ____ **Bottle fed** ____ At what age was it stopped? ______

Yes / No Is your home water supply fluoridated?

Yes / No Does your child use toothpaste containing fluoride?

Yes / No Do you give your child any other form of fluoride? What? ______________________

How often does our child brush his/her teeth? ____times per ____

Yes/No Does someone help your child to brush?

How often does your child floss his/her teeth? □ Never □ Occasionally □ Daily

Yes/No Does someone help your child to floss?

Yes/No Is there a family history of cavities?

If yes, indicate all that apply □ Mother □ Father □Sister □Brother

Does your child 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 your child is currently having problems with any of the following:

□ Cavities □ Toothache □ Sensitive Teeth □ Trauma

□ Gum Infections □ Color of Teeth □ Orthodontics □ Jaw Sounds

Yes / No Is your child shy? **Yes / No** Does your child **adjust well to new situations**?

How do you expect your child to respond to dental treatment?

□ Very Well □ Fairly well □ Somewhat poorly □ Very poorly

_________________________ _________________________ ___________

Signature of Parent/Guardian Relationship to Patient Date