1 Patient Information

Lakes Area Pediatric Dentistry

Child's Legal Name: ______________________________ Date of Birth: ______________

Nickname: ______________ Interests: ______________________________

☐ Female ☐ Male Weight:______ lbs Primary Phone: ______________ Secondary Phone: ______________

Primary Mailing Address:______________________ City: ______________ State: ______ Zip: ________

Responsible Party Information|Relationship to child Mother

Name: ______________________________

Date of Birth: ____________ Phone: ____________

Social Security:______________________________

Primary Address: ______________________________

Apartment number: ____________ PO Box: ____________

City: ______________ State: ______ Zip: ________

Email for appointment reminders:

____

Employer: ______________________________

Address: ______________________________

Phone: ______________________________

Who does the child live with? *(If different from responsible party)*

Name: ______________________________

Relationship to child: ______________________________

Date of Birth: ____________ Phone:____________

Social Security: ______________________________

Primary Address:______________________________

Apartment number: ____________ PO Box: ____________

City: ______________State: ______ Zip: ________

Email for appointment reminders:

____

Employer: ______________________________

Address: ______________________________

Phone: ______________________________

Responsible Party Information|Relationship to child Father

Name:______________________________

Date of Birth: ____________ Phone: ____________

Social Security: ______________________________

Primary Address: ______________________________

Apartment number:____________ PO Box:____________

City:______________ State:______ Zip: ________

Email for appointment reminders:

____

Employer:______________________________

Address:______________________________

Phone:______________________________

Who has legal custody? *(If different from above or responsible party)*

If Social Services has custody, please write what county, address of that office along with the name of the Social Worker and their phone number.

Name: ______________________________

Relationship to child: ______________________________

Date of Birth:____________ Phone: ____________

Social Security:______________________________

Primary Address: ______________________________

Apartment number: ____________ PO Box: ____________

City: ______________State: ______ Zip:________

Email for appointment reminders:

____

Employer: ______________________________

Address: ______________________________

Phone: ______________________________

I understand that the information 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 patient information.

I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent/guardian: ______________________________ **Today's Date:** ______________

(Please circle)

Relationship to Patient: Mother Father Step-Mother Step-Father Grandmother Grandfather Aunt Uncle Foster Mother Foster Father Social Worker Other: ______________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the APDA.

Dental Insurance Information & Patient Privacy Policy

Lakes Area Pediatric Dentistry

Patient(s) name: ______________________________

1

Primary Dental Insurance: ____________________
Policy Holder: ____________________
Subscriber ID: ____________________
Group: __________ Date of Birth: ___/___/___
Claims Address: PO Box: __________ City: __________
__________ State: ______ Zip: ______
Phone Number: ____________________
Social Security: ____________________
Employer: ____________________

2

Secondary Dental Insurance: ____________________
Policy Holder: ____________________
Subscriber ID: ____________________
Group: __________ Date of Birth: ___/___/___
Claims Address: PO Box: __________ City: __________
__________ State: ______ Zip: ______
Phone Number: ____________________
Social Security: ____________________
Employer: ____________________

3

Tertiary Dental Insurance: ____________________
Policy Holder: ____________________
Subscriber ID: ____________________
Group: __________ Date of Birth: ___/___/___
Claims Address: PO Box: __________ City: __________
__________ State: ______ Zip: ______
Phone Number: ____________________
Social Security: ____________________
Employer: ____________________

Medical Insurance (For hospital treatment only)
For example, if you are here for a consult today.

Medical Insurance: ____________________
Policy Holder: ____________________
Subscriber ID: ____________________
Group: __________ Date of Birth: ___/___/___
Claims Address: PO Box: __________ City: __________
__________ State: ______ Zip: ______
Phone Number: ____________________
Social Security: ____________________
Employer: ____________________

It is my responsibility to inform the dental office of any changes with my insurance. I authorize the dentist to release any information including diagnosis and the record of treatment or examination rendered to my child during the period of such dental care to a third party payor and/or health practitioners. I authorize and request my insurance carrier to pay the dentist directly. I understand that my dental insurance carrier may reimburse less than the actual service fees and I agree to be responsible for payment of all services rendered on the behalf of my dependent.

I have been offered a copy of this dental practice's privacy and breach notification policies and procedures. I understand that I should ask this dental practice's privacy official if I have any questions about these policies and procedures.

Patient(s) Name: ______________________________
Signature of Guardian: ______________________________ **Date:** ___/___/___
Print Name: ______________________________

3 Medical and Dental History

Lakes Area Pediatric Dentistry

Child's Legal Name: ______________________ Date of Birth: ______________

Has your child ever had a reaction to a problem with an anesthetic? Describe: ______________________

____

Is your child allergic to latex, metals, acrylic or dye? List: ______________________

____

List any other allergies you child has: ______________________

Primary Physician: ______________________ Facility Name: ______________________

Address: ______________________ City: ______________ State: ______ Zip: ________

Phone: ______________________ Is your child being treated by a physician at this time? Reason: ______________

____

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? List name, dose, frequency & date started: ______________________

____

Has your child ever been hospitalized, had surgery or had a significant injury? List date(s) and describe: ______________

____

4 Dental History

Does your child have a history of any of the following? For each "YES" response, please describe on lines below or please circle.

- ☐ 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 **Clenching/grinding his/her teeth**
- ☐ YES ☐ NO **Jaw joint problems (popping, etc.)**
- ☐ YES ☐ NO **Excessive gagging**

- ☐ YES ☐ NO **Sucking habit after one year of age**
  If yes, which:
  ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other
  For how long? ______________
- ☐ YES ☐ NO **Diet high in sugars or starches?**
- ☐ YES ☐ NO **Frequent snacks?**
- ☐ YES ☐ NO **Eat candy or other sweets?**
- ☐ YES ☐ NO **Drink pop, juice, fruit-flavored drinks, sports drinks or energy drinks?**
- ☐ YES ☐ NO **Goes to bed with a bottle?**
- ☐ YES ☐ NO **Uses a sippy cup?**

How often does your child brush their teeth? ______________ ☐ YES ☐ NO **Does someone help your child brush?**

How often does your child floss their teeth? ______________ ☐ YES ☐ NO **Does someone help your child floss?**

What is the source of drinking water at home? ☐ City/Community supply ☐ Private Well ☐ Bottled water

Please check all that apply for sources of fluoride your child receives:

☐ Drinking water ☐ Toothpaste ☐ Over-the-counter rinse ☐ Prescription rinse/gel ☐ Prescription drops/tablets/vitamins

☐ Fluoride treatment in the dental office ☐ Fluoride varnish by pediatrician/other practitioner

Received orthodontic treatment (braces, spacers, or other appliances? ☐ YES ☐ NO

Had a difficult dental appointment? ☐ YES ☐ NO

How do you expect your child will respond to dental treatment? ☐ Very Well ☐ Fairly Well ☐ Somewhat poorly ☐ Very Poorly

Additional Details:

____

5 Medical History

Turn for page 2 ⟶

5 Medical History

Please mark the box if your child has a history of the following conditions. If there's more than one option provided, circle the intended answer. Provide details at the bottom of the page.

Abuse
- ☐ Emotional
- ☐ Neglect
- ☐ Physical
- ☐ Psychological
- ☐ Sexual

Birth/Development
- ☐ Birth defects
- ☐ Complications before/during birth
- ☐ Inherited conditions
- ☐ Issues with physical growth or development
- ☐ Prematurity
- ☐ Syndromes: ____________________

Behavioral/Developmental
- ☐ Anxiety
- ☐ ADD/ADHD
- ☐ Autism/ASD
- ☐ Behavioral issues
- ☐ Communication issues
- ☐ Depression
- ☐ Developmental Disorders
- ☐ Emotional issues
- ☐ Intellectual disability
- ☐ Learning problems/delays
- ☐ Psychiatric problems

Cardiovascular
- ☐ Congenital heart defect/disease
- ☐ Heart murmur *Current or Innocent*
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Rheumatic fever
- ☐ Rheumatic heart disease

Dermatology
- ☐ Eczema
- ☐ Hives
- ☐ Jaundice (not at birth)
- ☐ Methicillin Resistant Staphylococcus Areus (MRSA)
- ☐ Rash
- ☐ Skin problems

Urology
- ☐ Bladder issues
- ☐ Kidney problems

Dietary
- ☐ Concerns about weight
- ☐ Dietary restrictions
- ☐ Eating disorder
- ☐ Food allergies
- ☐ Lactose Intolerance
- ☐ Nutritional deficiencies
- ☐ Unintentional weight loss

Digestive
- ☐ Hepatitis
- ☐ Liver problems

Ears, Nose and Throat
- ☐ Chronic adenoid/tonsil infections
- ☐ Ear tubes
- ☐ Excessive gagging
- ☐ Impaired hearing
- ☐ Lumps
- ☐ Neck stiffness
- ☐ Nose bleeds
- ☐ Scarlett Fever
- ☐ Sinusitis
- ☐ Swollen glands

Endocrine
- ☐ Diabetes (Hyperglycemia or Hypoglycemia)
- ☐ Thyroid
- ☐ Pituitary Problems
- ☐ Precocious Puberty or Hormonal Problems

Eyes
- ☐ Impaired Vision
- ☐ Visual Processing

Gastroenterology
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ GERD
- ☐ Heartburn
- ☐ Nausea
- ☐ Stomach ulcer

Immune
- ☐ Human Immunodeficiency Virus (HIV/AIDS)
- ☐ Mononucleosis

Hematology
- ☐ Anemia
- ☐ Blood disorder
- ☐ Bruising easily
- ☐ Excessive bleeding
- ☐ Hemophilia
- ☐ Receiving blood products
- ☐ Sickle Cell Disease/trait Transfusions

Neurology
- ☐ Brain injury
- ☐ Cerebral Palsy
- ☐ Convulsions
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Hydrocephaly or placement of a shunt *(Ventriculoperitoneal, ventriculoatrial, ventriculovenous)*
- ☐ Migraines
- ☐ Seizures

Oncology
- ☐ Bone Marrow
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Tumor
- ☐ Organ Transplant
- ☐ Other malignancy
- ☐ Radiation Therapy

Respiratory
- ☐ Asthma
- ☐ Breathing problems
- ☐ Cough
- ☐ Chest pain
- ☐ Cystic Fibrosis
- ☐ Frequent colds
- ☐ Frequent exposure to tobacco smoke
- ☐ Loud snoring/stop breathing
- ☐ Mouth Breathing
- ☐ Pneumonia
- ☐ Reactive airway disease
- ☐ Shortness of breath
- ☐ Tuberculosis (TB)
- ☐ Wheezing when sleeping

Details: ____

6

Signature of parent/guardian: ______________________ **Today's Date:** ____________

(Please circle)

Relationship to Patient: Mother Father Step-Mother Step-Father Grandmother Grandfather Aunt Uncle Social Worker Foster Mother Foster Father Other: ____________