INDIAN SPRINGS
PEDIATRIC DENTISTRY

Today's Date____________________________

*NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.*

Child's Name ______________________________________________________________ Gender: ☐ M ☐ F
First Middle Last

Preferred Name:_____________________________________

Siblings that we treat_________________________________ Hobbies____________________________________

Child's Birthdate _______/_______/_______ Child's Age_________ SS#______________________

School_______________________________________________ Grade__________________________

Child's Home # (____)________________________________________

Child's Home Address___________________________________ ________________________________ ____________
Number and Street City/State Zip

Name of child's physician___________________________Telephone______________________ Date last seen___________

Pharmacy______________________________________ Telephone____________________________________

Emergency Contact___________________________________________ Telephone______________________________
Name Relationship to patient

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

**Reason for today's visit**:______________________________________________________________________

Parent's Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

**Mother's Information**

Name:________________________________________

Mother Stepmother Guardian Birthdate ____/_____/_____

Occupation___________________________________

Employer____________________________________

Work# (______)_____________________Ext_________

Home# (______)_________________________________

Cellular Phone # (_____)_________________________

SS#____________________ DL#___________________

**Father's Information**

Name:________________________________________

Father Stepfather Guardian Birthdate____/_____/_____

Occupation___________________________________

Employer____________________________________

Work#(______)_____________________Ext_________

Home# (______)_________________________________

Cellular Phone # (_____)_________________________

SS#____________________ DL#___________________

Patient Name_______________________

Who is accompanying the child today?

Name______________________________________________________________

Relationship_________________________________________________________

Do you have legal custody of this child? ☐ Yes ☐ No

Person Responsible for Account

Name ______________________________________________________________

Relationship_________________________________________________________

Billing Address_______________________________ _______________________________ __________
Number and Street City/State Zip

Telephone ___________________________________________________________________________
Home Cell Work (Please circle the best number to contact you)

Email___________________________________

**Primary Dental Insurance**

Insurance Co. Name___________________________

Insurance Co. Address_________________________

_________________________________________

Insurance Co. Phone#_________________________

Group #:__________________________________

**Policy Owner's** Name:________________________

Relationship to Patient:________________________

**Policy Owner's** Birth Date:___________________

**Policy Owner's** SS#:__________________________

**Policy Owner's** Employer:_____________________

Employer's Address:_____________________________

**Secondary Dental Insurance**

Insurance Co. Name___________________________

Insurance Co. Address_________________________

_________________________________________

Insurance Co. Phone#_________________________

Group #:__________________________________

**Policy Owner's** Name:________________________

Relationship to Patient:________________________

**Policy Owner's** Birth Date:___________________

**Policy Owner's** SS#:__________________________

**Policy Owner's** Employer:_____________________

Employer's Address:_____________________________

Patient Name____________________________

## Health History

1. Is your child being treated by a physician at this time? ☐ Yes ☐ No
   If yes, why?____________________________________________________________

2. Has your child ever been a patient in a hospital? ☐ Yes ☐ No
   If yes why?____________________________________________________________

3. Has your child ever received general anesthesia or sedation? ☐ Yes ☐ No
   If yes, when?____________________________________________________________

4. Is your child allergic to anything? (medicine, food) ☐ Yes ☐ No
   If yes, what?____________________________________________________________

5. Is your child taking any medicines at this time? ☐ Yes ☐ No
   If yes, what?____________________________________________________________

6. Were there any problems at birth/premature delivery? ☐ Yes ☐ No
   If yes, what?____________________________________________________________

7. Are immunizations up to date? ☐ Yes ☐ No

8. Do you consider your child to be:
   ☐ advanced in the learning process
   ☐ progressing normally
   ☐ slow in the learning process

9. How do you think your child will cooperate for this appointment:
   ☐ Well behaved
   ☐ Unsure
   ☐ Uncooperative

10. Has your child ever been diagnosed with any of the following conditions? Please check **yes** or **no**

☐ Y ☐ N Anemia
☐ Y ☐ N Allergy
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma
☐ Y ☐ N Autism
☐ Y ☐ N Brain injury
☐ Y ☐ N Bronchitis
☐ Y ☐ N Cancer
☐ Y ☐ N Cerebral Palsy
☐ Y ☐ N Cleft lip/palate
☐ Y ☐ N Congenital birth defects
☐ Y ☐ N Convulsions/seizures
☐ Y ☐ N Cystic Fibrosis
☐ Y ☐ N Diabetes
☐ Y ☐ N Drug or alcohol abuse
☐ Y ☐ N Eczema
☐ Y ☐ N Epilepsy
☐ Y ☐ N Eye Problems
☐ Y ☐ N Fainting
☐ Y ☐ N Gastric Reflux Disease
☐ Y ☐ N Headaches
☐ Y ☐ N Hearing Loss
☐ Y ☐ N Heart Disease
☐ Y ☐ N Hepatitis-Type________
☐ Y ☐ N High/Low Blood Pressure
☐ Y ☐ N HIV/AIDS
☐ Y ☐ N Hyperactivity/ADD/ADHD
☐ Y ☐ N Jaundice
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Problems
☐ Y ☐ N Measles
☐ Y ☐ N Mononucleosis
☐ Y ☐ N Mouth Breathing
☐ Y ☐ N Nutritional Deficiency
☐ Y ☐ N Orthopedic Problems
☐ Y ☐ N Excessive Bleeding Problems
☐ Y ☐ N Intellectual /Developmental Disability
☐ Y ☐ N Pneumonia
☐ Y ☐ N Pregnant
☐ Y ☐ N Psychiatric Disorder
☐ Y ☐ N Respiratory Problems
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Scarlet Fever
☐ Y ☐ N Scoliosis
☐ Y ☐ N Sickle Cell Disease/Trait
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Snoring/Sleep Apnea
☐ Y ☐ N Sore throats-frequent
☐ Y ☐ N Spina Bifida
☐ Y ☐ N Syndrome____________
☐ Y ☐ N Tetanus
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Venereal Disease/STD
☐ Y ☐ N Other_____________
_____________________

☐ **This child has never been diagnosed as having any of the above conditions**

Patient Name______________________________

## Dental History

1. Is this your child's first visit to the dentist? ☐ Yes ☐ No
   If no, when was the date last seen___________________ Name of dentist______________________________

2. Has your child ever had dental radiographs (x-rays) made? ☐ Yes ☐ No
   If yes, when?_______________________________________________________________________________________

3. Has your child received fluoride in any form? ☐ Yes ☐ No
   If yes, what?_______________________________________________________________________________________

4. How many times a day does your child brush their teeth?_________________________________________

5. Do you brush your child's teeth? ☐ Yes ☐ No

6. Does your child floss his/her teeth? ☐ Yes ☐ No

7. At what age did your child stop bottle/breast feeding? ☐ Yes ☐ No

8. Does your child have snacks in between meals? ☐ Yes ☐ No

9. Have there been any injuries to any teeth? ☐ Yes ☐ No
   If yes, explain_____________________________________________________________________________________

10. Has your child had nay problem with dental treatment in the past? ☐ Yes ☐ No
    If yes, explain____________________________________________________________________________________

11. Does your child smoke or use tobacco products? ☐ Yes ☐ No

12. Does your child have any of the following habits (**Check all that apply**)

☐Clenching/Grinding ☐Lip Sucking/Biting ☐Mouth Breather ☐Nail Biting
☐Prolonged Bottle/Pacifier ☐Thumb/Finger sucking ☐Tongue Thrusting

Is there anything else that you think we should know about your child_____________________________________________________

_______________________________________________________________________________________________________________

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. It is also my responsibility as the parent/legal guardian to inform this office of any changes in my child's medical and dental status. I will not hold Dr. Crawford-McKendall or any staff member of Indian Springs Pediatric Dentistry responsible for any errors or omissions I may have made in completion of these forms.

Since ____________________________________________ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all dental services can be performed by Dr. Rosalynn Crawford-McKendall. Authorization is hereby granted to Dr. Crawford-McKendall and shall remain in force and in effect until canceled by either party.

_________________________________________ _________________________________ ____________________
Signature of parent/legal guardian Relationship to patient Date

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**For Office Use Only**

Reviewer___________________________________________________ Date______________________

Comments:___________________________________________________________________________________________________

_______________________________________________________________________________________________________________