Idaho Pediatric Dentistry

SAVING TEETH, ONE KID AT A TIME

Welcome to Idaho Pediatric Dentistry. The entire staff would like to welcome you to our dental office, providing care exclusively for children. Our primary goal is to make every visit fun & educational for your child, as we strive to teach good oral hygiene that will enable our patients to maintain a beautiful smile for a lifetime!

So we are able to provide the safest comprehensive dental care possible, we ask that you complete this detailed medical form. Please feel free to ask questions about any item that you are not familiar.

Today's Date _____

Patient's Name _____ Nickname _____

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Date of Birth _____ ☐ Male ☐ Female

How did you find us? ☐Friend _____ ☐Doctor's Referral _____ ☐Yellow Pgs ☐Mailer ☐Newspaper ☐ PBS ☐Web Site

Medical History.

Rev Med Hx:

Official Use Only

Sister(s):
Brother(s):

Has your child ever had any of the following conditions?

Yes	No		Yes	No	
☐	☐	Sickle Cell Anemia or Trait	☐	☐	Measles, Mumps, or Chicken Pox (*when?* _____)
☐	☐	Bleeding Disorder or Hemophilia _____	☐	☐	Skin Disorder or Eczema _____
☐	☐	Blood Transfusion (*date(s)*_____)	☐	☐	Tonsillectomy and/or Adnoidectomy (*when?* _____)
☐	☐	Hypertension	☐	☐	Chronic Ear Infections / Otitis Media
☐	☐	Anemia	☐	☐	Tuberculosis or Positive Test Result (*when?* _____)
☐	☐	Heart Murmur (*Innocent or Pathological)*	☐	☐	Sexually Transmitted Disease _____
☐	☐	Tetralogy of Fallot	☐	☐	Immunologic Disorder, HIV, AIDS or ARC
☐	☐	Heart Condition_____	☐	☐	Hepatitis (*Type* ____)
☐	☐	Rheumatic Fever	☐	☐	Hearing Impairment (*Right, Left or Both*)
☐	☐	Bruises or Bleeds Easily	☐	☐	Eye Problem _____ (*Right, Left or Both*)
☐	☐	Cystic Fibrosis	☐	☐	Chronic Constipation
☐	☐	Asthma or Lung Problems (*Inhaler, Nebulizer*)	☐	☐	Stomach/GI Disorder _____
☐	☐	Pneumonia (*when?* _____)	☐	☐	Appendectomy (*when?* _____)
☐	☐	Seasonal Allergies, Hay Fever, etc.	☐	☐	Thyroid Disorder
☐	☐	Cancer, Malignancy, Leukemia or Lymphoma	☐	☐	Diabetes Mellitus (*NIDDM or IDDM*_____ *x day*)
☐	☐	Febrile Seizure, Fainting Spells	☐	☐	Currently Pregnant _____
☐	☐	Seizure Disorder, Epilepsy (*Last Episode* _____)	☐	☐	Implanted Shunt, Pin, Plate, Screw, or Rod
☐	☐	Tobacco, Drug, or Alcohol Use	☐	☐	Premature Birth (*Weeks* _____)
☐	☐	Diagnosed with ADD, ADHD or Hyperactivity	☐	☐	Cleft Lip/Palate (*Bilateral, Unilateral*)
☐	☐	Emotional or Behavioral Problems	☐	☐	Congenital Birth Defects/Syndrome _____
☐	☐	Psychiatric Problems _____	☐	☐	Learning Disability (*Mild, Moderate, Severe*)
☐	☐	Physical or Emotional Abuse _____	☐	☐	Autistic (*Mild, Moderate, Severe*)
☐	☐	Neurological Disorder, Hydrocephaly	☐	☐	Cerebral Palsy, Muscular Dystrophy
☐	☐	Kidney Disease or Transplantation	☐	☐	Handicaps or Disabilities _____
☐	☐	Urinary Tract Disorder _____	☐	☐	Delayed Development, MR (*Approx age child functions*_____)
☐	☐	Liver Disease or Transplantation	☐	☐	Any Hospital Stays? _____

Is your child's immunization record current? ☐ Yes ☐ No

Please list all **medications** patient is currently taking _____

Is your child **allergic** or ever had an **adverse reaction** to a medication? ☐Yes ☐No If so, which? _____

Does your child have an **allergy** to latex, foods or dyes? ☐Yes ☐No If so, which? _____

Other Medical Conditions Not Noted Above: _____

Please list the names & phone numbers of any physicians that are currently treating your child.

Type of Physician	Doctor's Name	Office Phone Number
Pediatrician		

When was your child's last medical check-up at his/her pediatrician? _____

Dental History.

Has your child ever suffered from any of the following dental related problems?

Yes	No		Yes	No	
☐	☐	Bad Breath / Halitosis	☐	☐	Popping or Soreness of the Jaws (*Right, Left or Both*)
☐	☐	Bleeding Gums	☐	☐	Dental Infection or Abscess
☐	☐	Stained or Discolored Teeth	☐	☐	Pain from Teeth
☐	☐	Cold Sores or Fever Blisters	☐	☐	Missing or Extra Teeth
☐	☐	Dry Mouth	☐	☐	Previous Injury or Trauma to Teeth, Mouth or Face

If so, please explain _____

Has your child expressed any dental anxiety? ☐ Yes ☐ No _____

Has your child been prescribed fluoride supplements? ☐ Yes ☐ No _____

Does your child brush their teeth two times a day? ☐ Yes ☐ No If so, do you assist? ☐ Yes ☐ No

Does your child suck a thumb, finger, pacifier or blanket? ☐ Yes ☐ No

How would you predict your child's behavior to be today? ☐ Cooperative ☐ Nervous ☐ Defiant ☐ Don't Know

How would you describe your child's current oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

Has your child ever been treated by a dentist? ☐ Yes ☐ No A pediatric dentist? ☐ Yes ☐ No If so, who?_____

What are your primary concerns regarding your child's oral health? _____

_____

Person(s) Responsible for Account.

Mother's Information: ☐ Mother ☐ Step Mother ☐ Legal Guardian ☐ Grandmother

Name:	Date of Birth:	Occupation:
Address:	Social Security #	Employer:
City & State:	Zip:	For how long?
Home Phone:	Marital Status: S M D	Work/Cellular Phone:

Father's Information: ☐ Father ☐ Step Father ☐ Legal Guardian ☐ Grandfather

Name:	Date of Birth:	Occupation:
Address:	Social Security #	Employer:
City & State:	Zip:	For how long?
Home Phone:	Marital Status: S M D	Work/Cellular Phone:

Emergency Information.

In the case of an emergency where neither parent or legal guardian can be reached, please identify the following information for the next **closest relative** not living with the patient.

Name _____ Relation_____

Address _____ Phone_____

Dental Insurance Information. ❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖

Insurance Co. Name_____ Insurance Co. Phone _____
Group Number _____ Local Number _____ Policy Number _____
Who is the primary person on this policy? _____ What is their SS#_____

Do You Have Secondary Insurance? ☐ Yes ☐ No

Secondary Insurance Co. Name_____ Insurance Co. Phone _____
Group Number _____ Local Number _____ Policy Number _____
Who is the primary person on this policy? _____ What is their SS#_____

Medical/Dental Release Statements. ❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖❖

I give my consent to the doctor(s) of Idaho Pediatric Dentistry to complete a thorough examination on the previously named patient, including all needed diagnostic radiographs. To the best of my knowledge, the information that I have provided is accurate and I understand that it will be held in the strictest of confidence and in accordance to all sate & federal HIPAA regulations. Furthermore, I understand that it is my responsibility to inform Idaho Pediatric Dentistry of any future changes to my child's medical history status. As the parent or legal guardian of the previously named patient, I also hereby grant the doctor(s) and staff of Idaho Pediatric Dentistry permission to perform future treatment(s) as deemed appropriate. I understand that all necessary treatment and costs will be explained prior to commencement and that I am responsible for payment in full at the time services are rendered, unless prior arrangements have been made in writing._____
Initial

Insurance Claim Release & Financial Responsibility Statement. To precipitate the filing of today's and all future dental insurance claims, I do hereby authorize the release of confidential information to and from my child's dental insurance company. I understand that Idaho Pediatric Dentistry files such claims as a courtesy to its patients. I am also aware that Idaho Pediatric Dentistry will provide me with an estimate of insurance coverage, as well as my estimated out-of-pocket expense prior to initiating such treatment and that I am legally responsible for any portions not paid by this policy. I understand that additional out-of-pocket expenses may be accrued should estimates provided by my insurance company be inaccurate or should procedures change during the course of treatment. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 30-days of receiving such treatment._____
Initial

Authorization for Direct Payment. I hereby authorize payment of insurance benefits directly to Idaho Pediatric Dentistry or the dentist(s) that performs treatment on my child. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount._____
Initial

_____ _____
Signature of Parent or Legal Guardian Date

PATIENT WEIGHT LOG

Date	Weight	Date	Weight	Date	Weight

Is the patient's medical/dental insurance current? ☐ Yes ☐ No	
Have there been any medical changes since last visit? ☐ Yes ☐ No	New Medical Findings:
Is the patient taking any new medications? ☐ Yes ☐ No	New Medications:
Have there been any dental changes since last visit? ☐Yes ☐ No	New Dental Problems:

Date: ____________________ Doctor's Signature_____________________________________

WT: *lbs* **OH**: (--) (-) (+) (++) **BEH**: (--) (-) (+) (++) **NV**: ☐ 6MR ☐ RSD w/ N2O ☐ OCS/IV SED

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Is the patient taking any new medications? ☐ Yes ☐ No	New Medications:
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Date: ____________________ Doctor's Signature_____________________________________

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Have there been any dental changes since last visit? ☐Yes ☐ No	New Dental Problems:

Date: ____________________ Doctor's Signature_____________________________________

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