Welcome to

Pediatric Dentistry of Loveland

Please fill out this form and bring it with you on your first office visit.

About Your Child

Child's Name________________________________
First Middle Last

Child's Nickname ___________________________

Age ____________________ ☐Male ☐Female

Date of Birth______________ Weight_________

Reason for Visit____________________________

____

How did you hear about our office?____________

School Name__________________ Grade______

Child's SSN#_______________________________

Preventative Dental History

How often does your child brush?______________

Is toothbrushing supervised? ☐ Yes ☐ No

If yes, by whom?_________________________

Is dental floss used? ☐ Yes ☐ No

Does your child receive:

☐ Fluoride in vitamins
☐ Fluoride tablet/drops
☐ Fluoride toothpaste
☐ Non-fluoride paste (infant toothpaste)
☐ Fluoridated water
☐ Bottled water
☐ Well water

What does your child drink most often?__________

____

Dental History

Is this your child's first dental visit? ☐Yes ☐No

Previous Dentist________________________

City______________________________

Date of Last Visit_______________________

Date of Last Dental X-Rays______________

Any injuries to your child's teeth? ☐ Yes ☐ No

If yes, when?__________________________

History of:	When?
☐ Breast feeding	______________
☐ Bottle habits (sleeping with bottle)	______________
☐ Thumb/finger sucking	______________
☐ Pacifier	______________
☐ Dental grinding or clenching	______________

Has your child had any unfavorable past dental experiences? ☐ Yes ☐ No

If yes, explain_________________________

____

Has your child had recent dental pain?_______

____

Child's name:____________________

Pediatric Dentistry of Loveland

Medical History

____
Name of Child's Physician

______________________________ ________________
Address Phone Number

____
Date of Last Physical Exam

Is your child presently under the care of a specialist for any medical reason? ☐Yes ☐No

If yes, for what? ___________________________________

____
Specialist's Name Phone Number

- Does your child have a history of health problems? ☐Yes ☐No If yes, explain: ____
- Are antibiotics necessary for dental work because of a heart murmur, heart defect, prosthesis, shunt, or other medical reason? ☐Yes ☐No
- Is your child presently taking any medications? What?____________________ ______________________________ ☐Yes ☐No
- Has your child ever been hospitalized or had surgery? For what?__________________ ☐Yes ☐No
- Does your child have any allergies? If yes, what? __________________________ ______________________________ ☐Yes ☐No
- Has any member of the family, including your child, had a problem with a general anesthetic? ☐Yes ☐No

Medical Condit i ons

Has your child ever been diagnosed as having any of the following conditions? Check ☑ all that apply

- ☐ Acid Reflux
- ☐ AIDS-HIV
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma, If ☑ what triggers it? ________________________
- ☐ Autism
- ☐ Bladder Conditions
- ☐ Blood Disease
- ☐ Birth Defects
- ☐ Bone or Joint Problems
- ☐ Brain Injury
- ☐ Bruising easily
- ☐ Cancer or Malignancies
- ☐ Cerebral Palsy
- ☐ Chemotherapy/Radiation
- ☐ Child Abuse
- ☐ Chronic Adenoid/Tonsil Infections
- ☐ Chronic Ear Infections
- ☐ Cleft Lip/Palate
- ☐ Congenital Heart Lesion
- ☐ Convulsions/Seizures
- ☐ Developmentally Disabled
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Ear Stuffiness, Itching, or Noises
- ☐ Emotional Disturbance
- ☐ Epilepsy
- ☐ Eye Problems
- ☐ Excessive Bleeding Problem
- ☐ Excessive Gagging
- ☐ Fainting or Dizziness
- ☐ Fever Blisters (Cold Sores)
- ☐ Growth/Developenta'l Probs.
- ☐ Headaches
- ☐ Hearing/Speech Impairments
- ☐ Heart Defect
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis or Liver Disease
- ☐ High Blood Pressure
- ☐ Hyperactivity/ADD or ADHD
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Mental Disability
- ☐ Mouth Sores
- ☐ Nutritional Deficiency
- ☐ Orthopedic Problems
- ☐ Pain in Jaw Joints
- ☐ Premature Birth
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Sickle Cell Anemia
- ☐ Syndrome ________________
- ☐ Tuberculosis

☐ Other____

Primary Dental Insurance

Insurance Co.________________________________

Policy Holder Name ___________________________

Employer____________________________________

Policy Holder SSN# ___________________________

Group# _____________________________________

Membership # or ID ___________________________

Claim Address________________________________

Claim City__________________ State____ Zip______

Insurance Co. Phone No. _______________________

Secondary Dental Insurance

Insurance Co.________________________________

Policy Holder Name ___________________________

Employer____________________________________

Policy Holder SSN# ___________________________

Group# _____________________________________

Membership # or ID ___________________________

Claim Address________________________________

Claim City__________________ State____ Zip_______

Insurance Co. Phone No. _______________________

Child's name:____________________

Pediatric Dentistry of Loveland

Responsible Party

☐Mother ☐Stepmother
☐Grandmother ☐Legal Guardian

Name___________________________________

Address_________________________________

City________________ State______ Zip_______

Does child live at this address? ☐Yes ☐No

SS#_________________ Birthdate____________

Home Phone #________ Cell Phone#_________

Employer_____________ Occupation__________

Work Phone # ___________

Best phone number to Call:
☐ Home ☐ Cell ☐ Work

Emergency Contact
(other than responsible party)

Name______________________________________

Home Phone__________ Cell Phone____________

Relationship_________________________________

Additional Family Members

________________________________ ___________
Name Birthday

________________________________ ___________
Name Birthday

________________________________ ___________
Name Birthday

________________________________ ___________
Name Birthday

Have your other children been seen in our office?
☐Yes ☐No

Were you or your spouse a former patient?
☐Yes ☐No

☐Father ☐Stepfather
☐Grandfather ☐Legal Guardian

Name___________________________________

Address_________________________________

City________________ State______ Zip_______

Does child live at this address? ☐Yes ☐No

SS#_________________ Birthdate____________

Home Phone #________ Cell Phone#_________

Employer_____________ Occupation__________

Work Phone # ___________

Best phone number to Call:
☐ Home ☐ Cell ☐ Work

Authorization

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that **payment is due at the time services are rendered**. I also request that payment under my dental insurance program be made directly to Pediatric Dentistry of Loveland on any unpaid bills for services furnished to me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

By providing us with your landline/cell phone number, you give express authorization to contact you at those numbers. This express authorization also applies to to any landline/cell phone numbers you acquire in the future. Phone calls to you may be made utilizing automated dialer technology. Providing your phone number is not a condition of receiving services .

____
Signature

____
Date

The permission of a parent or guardian is necessary for dental treatment of a minor.

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (X-rays), and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, anesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions that my child's medical doctor has advised me should be reported to a dentist.

________________________________ ______________________________ ___________
Signature *Relationship to Child* *Date*