

Pediatric Dentistry of Salem

Today's Date _____

Who can we thank for referring you to our office? _____

Your child

First

Last

Child's Name _____ Sex _____ Age _____

Nickname _____ Birthdate _____

Child's Home Address _____

City, State, Zip _____ Phone _____

Parent or Guardian Information

Mother

Stepmother

Guardian

Name _____ Birthdate _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Address _____ SS# _____

Marital Status Single Married Separated Divorced Widowed

Parent or Guardian Information

Father

Stepfather

Guardian

Name _____ Birthdate _____

Address _____

City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Employer _____ Occupation _____

Address _____ SS# _____

Marital Status Single Married Separated Divorced Widowed

Primary Dental Insurance

Insured's Name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer Name _____ Work Phone _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Payor ID# _____

Insurance Company Address _____ City _____ State _____ Zip _____

Additional Dental Insurance

Insured's Name _____ Relationship _____

Birthdate _____ Social Security # _____

Employer Name _____ Work Phone _____ Occupation _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group# _____ Payor ID# _____

Insurance Company Address _____ City _____ State _____ Zip _____

DENTAL HISTORY

What would you like us to do for your child today? _____

Previous Dentist _____ Address _____ Phone _____

Date of last dental care _____ Date of last X-Rays _____

How often does your child brush? _____ Floss? _____

Does your child experience pain or discomfort in the jaw joint? Yes No

Has your child ever experienced a mouth or chin injury? Yes No

Does your child have any speech difficulties? _____ If so, any speech therapy? _____

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes No If yes, describe _____

Child's habits affecting mouth or teeth? Thumb/Finger Sucking Nail Biting Pacifier Other

Other information about your child's dental health or previous treatment _____

Is there anything else about your child you feel would be important for us to know? _____

List two nearest relatives or friends not living with you in case of an emergency

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

MEDICAL HISTORY

Child's Physician _____ Phone _____

Date of last visit _____ Has your child had any serious illnesses or operations? Yes No

If yes, describe _____

Is your child currently under physician care? Yes No If yes, describe _____

Has your child ever had a blood transfusion? Yes No If yes, give approximate dates _____

Check(√) If your child has had any of the following:

- ADD/ADHD Diabetes Hemophilia/Abnormal Bleeding Seizures
- AIDS/HIV Positive Epilepsy Hepatitis Shortness of Breath
- Anemia Fainting Immunizations Current Sinus Problems
- Asthma Food Allergies Kidney Disease or Malfunction Skin Rash
- Autism Spectrum Headaches Liver Disease Spina Bifida
- Blood Disease Hearing Impairment Material Allergies Thyroid Disease
- Cancer Heart Problems Latex, Wool, Metal, Chemicals Tonsillitis
- Cough, Persistent describe _____ Respiratory Disease Tuberculosis
- Developmental Disability Heart Murmur Rheumatic/Scarlet Fever Other _____

List any medication your child is taking: _____ List any drug allergies: _____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I acknowledge receipt of HIPAA Compliance Information and have read and understand all the terms above as well as the office and financial policies and agree to their content.

I authorize the dentist to release all information necessary to secure the payment of benefits, I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that if my account is not paid within 60 days of the date of service and no financial arrangements have been made, that I will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting on my account.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been made.