Thank you for selecting
Pediatric Dentistry of Salem LLC

Today's Date ______________

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

YOUR CHILD First Last

Child's Name ______________________ Sex __________ Age ______

Nickname ______________________ Birthdate ______________

Child's Home Address ______________________________

City, State, Zip ______________________ Phone ______________

RESPONSIBLE PARTY *(Person responsible for any remaining balances once insurance clears)*

Name ______________________ Relationship ______________

Address ______________________________

City, State, Zip ______________________ Phone ______________

Social Security # ______________________________

Who is Responsible for Making Appointments? ______________________

PARENT OR GUARDIAN INFORMATION ☐ **Mother** ☐ **Stepmother** ☐ **Guardian**

Name ______________________ Birthdate ______________

Home Phone ( ) __________ Cell Phone ( ) __________ Work Phone ______________

Address ______________________ City __________ State ______ Zip ______

SS# ______________ Employer ______________ Occupation ______________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PARENT OR GUARDIAN INFORMATION ☐ **Father** ☐ **Stepfather** ☐ **Guardian**

Name ______________________ Birthdate ______________

Home Phone ( ) __________ Cell Phone ( ) __________ Work Phone ______________

Address ______________________ City __________ State ______ Zip ______

SS# ______________ Employer ______________ Occupation ______________

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

PRIMARY INSURANCE

Insured's Name ______________________ Relationship ______________

Birthdate ______________________ Social Security # ______________

Employer Name ______________ Work Phone __________ Occupation __________

Employer Address ______________ City __________ State ______ Zip ______

Insurance Co. ______________ Group # __________ Payor ID# __________

Insurance Co. Address ______________ City __________ State ______ Zip ______

ADDITIONAL INSURANCE

Insured's Name ______________________ Relationship ______________

Birthdate ______________________ Social Security # ______________

Employer Name ______________ Work Phone __________ Occupation __________

Employer Address ______________ City __________ State ______ Zip ______

Insurance Co. ______________ Group # __________ Payor ID# __________

Insurance Co. 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 Sucking ☐ Nail Biting ☐ 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 ____________

Name ____________________ Phone ____________

MEDICAL HISTORY

Child's Physician ____________________ Phone ____________ Date of last visit ____________

Any serious illnesses or surgeries? ☐ Yes ☐ No Please describe ____________________

Currently under physician's care? ☐ Yes ☐ No Please describe ____________________

Ever had a blood transfusion? ☐ Yes ☐ No Please describe ____________________

Please check if your child has ever had any of the following conditions:

- ☐ ADD/ADHD
- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Asthma
- ☐ Autism Spectrum
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cough, Persistent
- ☐ Developmental Disability
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food Allergies
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Hemophilia/Abnormal Bleeding
- ☐ Immunizations Current
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Material Allergies *(Latex, Wool, Metal, Chemical)*
- ☐ Respiratory Disease
- ☐ Rheumatic/Scarlet Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Problems
- ☐ Skin Rash
- ☐ Spina Bifada
- ☐ Thyroid Disease
- ☐ Tonsilitis
- ☐ Tubercolosis
- ☐ Other

List medications your child is taking, if any: ____________________

List drug and food allergies, if any: ____________________

Comments ____________________

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 a 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 of the terms above as well as the office and financial policies and agree to their content.

I understand that the phone numbers listed (home, work, and cell) provide consent for the dental practice to utilize in all business matters, including but not limited to, appointment confirmation, emergency notification, and the collection of any unresolved debt.

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 prior 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: ____________________ Print Name: ____________________ Date: ____________

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