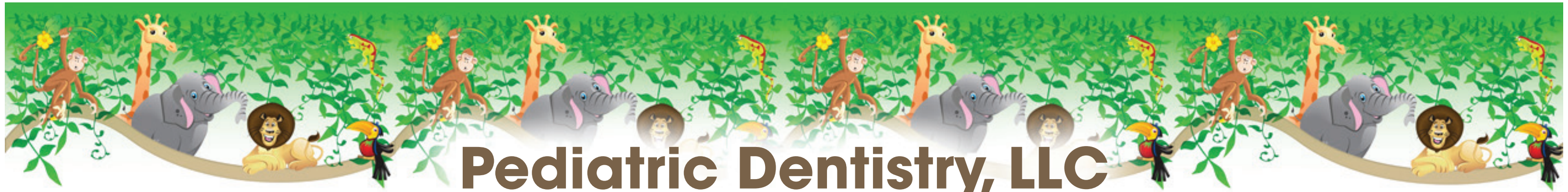

PARENT INFORMATION

GUARDIAN (I)

Name:______________________ Gender: __________

DOB: ______________ SS#: ____________________

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership

☐ Separated ☐ Divorced ☐ Widowed

Home:______________ Cell: ________________

Email:_______________________________________

Employer: ___________________________________

Work:____

GUARDIAN (II)

Name:______________________ Gender: __________

DOB: ______________ SS#: ____________________

Marital Status: ☐ Single ☐ Married ☐ Domestic Partnership

☐ Separated ☐ Divorced ☐ Widowed

Home:______________ Cell: ________________

Email:_______________________________________

Employer: ___________________________________

Work:____

Who does the patient live with?: ☐ Guardian 1& 2 ☐ Guardian 1 ☐ Guardian 2 ☐ Other:____________

Street Address: ______________________________ City: ____________ State:________ Zip: __________

Primary number for appointment confirmations:______________________ Email: ______________________

Who is accompanying the child today?

Name:____________________ Relation: ☐ Biological ☐ Adopted ☐ Foster ☐ Nanny ☐ Other:__________

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured: ____________________________

DOB: ______________ SS#: ____________________

Employer: ___________________________________

Phone: ______________________________________

Insurance Co.: ______________________________

Street Address: _____________________________

City:______________ State: _________Zip: __________

Phone: ______________________________________

Group/Policy #: _____________________________

I.D. #: _____________________________________

SECONDARY COVERAGE

Name of Insured: ____________________________

DOB:______________ SS#:______________________

Employer: ___________________________________

Phone: ______________________________________

Insurance Co.: ______________________________

Street Address: _____________________________

City:______________ State:_________Zip: __________

Phone: ______________________________________

Group/Policy #:______________________________

I.D. #: _____________________________________

REFERRAL INFORMATION

Please share with us how you heard about our office...

☐ Sibling(s):________________________________

☐ Friend:___________________________________

☐ Pediatrician/Physician: ____________________

☐ Dentist/Dental Office:______________________

☐ Insurance:_________________________________

☐ School/Daycare:____________________________

☐ Other:____________________________________

☐ Google

☐ Website

☐ Facebook

☐ Angie's List

☐ Print Ad (magazine, newspaper, etc.): ____________

☐ Community Event:_________________________

Name: ____________________ Preferred Name: ____________________ DOB: __________

Sex Assigned at Birth: ☐ M ☐ F Gender: __________ Preferred Pronouns: ____________________

DENTAL HISTORY

DENTAL CONCERNS

What is the primary reason for today's visit?: ☐ Cleaning ☐ Trauma/Dental Emergency ☐ Consult for Decay (Cavities)

Has your child ever been to the dentist?: ☐ Yes ☐ No (If Yes) Previous/Present Dentist: ____________________

Date Last Exam: __________ Date Last X-rays: __________

Describe your child: ☐ Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Age appropriate

How would you expect your child to behave in our office? ____________________

How may we help make this visit a positive experience for your child? ____________________

DENTAL HABITS

Does your child currently... (Check all that apply)

☐ Suck Thumb/Finger ☐ Suck/Bite Lips ☐ Bite/Chew Nails ☐ Bottle Feed Until what age? __________

☐ Use Pacifier ☐ Clench/Grind Teeth ☐ Mouth Breather ☐ Breast Feed Until what age? __________

HYGIENE ROUTINE

(Check all that apply)

☐ Fluoride Toothpaste ☐ Consume Fluoridated Water ☐ Fluoride Mouthwash ☐ Fluoride Supplement

☐ Brushing by Child: ______ /day ☐ Brushing by Parent: ______ /day ☐ Dental Floss: ______ /week

☐ Snacks between Meals - *Type of snacks*: ____________________ ☐ Cups of juice ______ /day

MEDICAL HISTORY

Are immunizations current?: ☐ Yes ☐ No

Child's physician: ____________________ Phone: __________ Date Last Exam: __________

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain): ____________________

____

Current Medications: ____________________

Has your child been diagnosed and/or treated for any of the following? (Check all that apply) ☐ None of the below

		ALLERGIES:
☐ Blood Disorder/Anemia	☐ Premature/Low Birth Weight	☐ Medication: __________
☐ Abnormal Bleeding/Hemophilia	☐ Asthma/Reactive Airway Disease	☐ Food: __________
☐ Immune Disorder/HIV/AIDS	☐ Mental/Cognitive/Social Delay	☐ Seasonal
☐ Cancer/Tumor/Leukemia	☐ Congenital Birth Defects	☐ Hives
☐ Heart Murmur/Defect/Surgery	☐ Cleft Lip/Palate	☐ Latex
☐ Epilepsy/Seizures/Convulsions	☐ Autism Spectrum	☐ Other (specify): __________
☐ Cerebral Palsy	☐ ADD/ADHD	☐ Comments/Details: __________
☐ Kidney Problems	☐ Eating Disorder	__________
☐ Liver Disease/Jaundice/Hepatitis	☐ Speech Disorder	__________
☐ Diabetes	☐ Vision Problems	__________
☐ Stomach/GI Disorders	☐ Hearing Problems/Deaf	

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the child's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Pediatric Dentistry of Portland, LLC may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Pediatric Dentistry of Portland, LLC all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

PARENT SIGNATURE ____________________ **RELATIONSHIP TO CHILD** __________ **DATE** __________

DOCTOR SIGNATURE ____________________ **DATE** __________