Small World
PEDIATRIC DENTISTRY, P. C.

Welcome!

Thank you for your visit today! We are pleased to welcome you and your child to our practice. To help us serve you better, please take a few moments to fill out the following form as completely as you can. If you have any questions, just ask—we will be glad to help. We look forward to working with you to maintain your child's dental health!

PATIENT INFORMATION

Date _____ Home Phone_____

Child's Name _____ Nickname _____

Sex: ☐ Male ☐ Female Age _____ Birthday _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____

Person financially responsible _____ Home Phone _____Work Phone _____

Whom may we thank for referring you? _____

Father's /Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ Work Phone _____

Employer _____

Social Security # _____ __Birthdate _____

Cell/Pgr.# _____

E-mail _____

Mother's /Guardian's Name _____

Address (if different from patient's) _____

_____

Home Phone _____ Work Phone _____

Employer _____

Social Security # _____ Birthdate _____

Cell/Pgr.# _____

E-mail _____

INSURANCE

Do you have dental insurance/coverage for child? ☐ Yes ☐ No

Plan Name _____

Address _____

Phone Number _____

Group # _____

Policy # _____

Do you have dental insurance/coverage for child? ☐ Yes ☐ No

Plan Name _____

Address _____

Phone Number _____

Group # _____

Policy # _____

DENTAL HISTORY

Date of last dental visit _____ For what service? _____

	Yes	No		Yes	No
Has child complained about dental problems?	☐	☐	Is fluoride taken in any form?	☐	☐
Does child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, or head?	☐	☐
Does child floss teeth daily?	☐	☐	Any unhappy dental experiences?.....	☐	☐

Any mouth habits–thumbsicking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? _____

MEDICAL HISTORY

Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No	
Is child under the care of a physician now?	☐	☐	Medications _____
Receiving any medication or drugs?	☐	☐	_____
Ever been hospitalized?	☐	☐	Allergies _____
Ever had surgery?	☐	☐	_____
Is there excessive bleeding when cut?	☐	☐	_____

HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING?

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS/HIV	☐	☐	Cerebral Palsy	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Chicken Pox	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Convulsions	☐	☐	Hearing Problems	☐	☐	Measles	☐	☐	Thyroid Disease
☐	☐	Bladder Problems	☐	☐	Diabetes	☐	☐	Heart Problems	☐	☐	Mononucleosis	☐	☐	Other
☐	☐	Cancer	☐	☐	Drug/Alcohol Abuse	☐	☐	Hepatitis	☐	☐	Mumps			

EMERGENCY INFORMATION

In the event of an emergency whom should we contact (other than yourself)?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATION

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment for my child, and I agree to notify the dentist if any change in my child's health status should occur.

I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill services. I agree to be responsible for payment of all services rendered on behalf of my dependents.

Signature of parent or guardian _____ Date _____

Payment is due in full at time of treatment,
Unless prior arrangements have been approved.