## PATIENT INFORMATION

Child's Full Name: ___________________________________DOB: __________ Nickname:______________

School: ________________________ Grade: _______ Sex: M/F Hobbies or favorite toys: ________________

Have we treated anyone in your family? Yes ____ NO _____ If yes, whom? ____________________________

Whom may we thank for referring you to our office? ______________________________________________

Who has legal custody of this child? ____________________________________________________________

## FAMILY INFORMATION

| MOTHER | FATHER |
|---|---|
| Last Name First Name MI | Last Name First Name MI |
| Street Address City, State, Zip | Street Address City, State, Zip |
| Home phone # Work phone # | Home phone # Work phone # |
| Cell phone # e-mail address | Cell phone # e-mail address |
| Birthdate (MM/DD/YY) SS# | Birthdate (MM/DD/YY) SS# |
| Employer | Employer |
| Dental Insurance Group # Contract # | Dental Insurance Group # Contract # |
| Drivers License # State | Drivers License # State |

Person to contact outside of immediate family in case of emergency: Name: ______________________________
Address: ________________________________________________ Phone: _______________ ______________
Street Address City, State, Zip Home phone Alternate phone

## DENTAL HISTORY

☐ Yes ☐ No Has your child ever been to a dentist: If yes, date of last dental visit: ______________________
Name of previous dentist: ____________________________ Phone #: ____________________
Date of last x-rays: Bitewings: ___________________ Panoramic: ______________________

☐ Yes ☐ No Have your child's teeth ever been injured (If yes, when)? ______________________________

☐ Yes ☐ No Does your child suck a thumb, finger or pacifier? Ages, when? __________________________

☐ Yes ☐ No Is your child currently breast or bottle feeding (If yes, circle one)?_______________________

☐ Yes ☐ No Does your child use a sippy cup? __________________________________________________

☐ Yes ☐ No Is your child currently seeing an orthodontist? (if yes, Doctor's Name)____________________

☐ Yes ☐ No Do you brush your child's teeth? __________________________________________________

☐ Yes ☐ No Does your child brush his/her own teeth? ___________________________________________

☐ Yes ☐ No Does your child use dental floss? _________________________________________________

☐ Yes ☐ No Do you think your child will react well to dental treatment?_____________________________

**PLEASE CHECK IF YOUR CHILD IS HAVING PROBLEMS WITH ANY OF THE FOLLOWING:**

☐ Cavities ☐ Color of Teeth ☐ Gum Infections ☐ Sensitive Teeth
☐ Toothache ☐ Orthodontics ☐ Jaw Pain ☐ Mouth Sores

Patient Name: ______________________________________

## PATIENT'S MEDICAL HISTORY

☐ Yes ☐ No Has your child ever had a health problem? ___________________________________________
Name of child's physician: _______________________________ Phone #: ________________
Date of last physical exam: ________________________________________________________

☐ Yes ☐ No Has your child had any operations/hospitalizations? ___________________________________

☐ Yes ☐ No Is your child currently taking any medications? _______________________________________

☐ Yes ☐ No Are your child's immunizations up to date? __________________________________________

**PLEASE CHECK YES OR NO ON ALL:**

| | | | | |
|---|---|---|---|---|
| ☐ Yes ☐ No | ADD/ADHD *(circle one)* | | ☐ Yes ☐ No | Ear problems |
| ☐ Yes ☐ No | AIDS/HIV | | ☐ Yes ☐ No | Heart Condition *(specify below)* |
| ☐ Yes ☐ No | Allergies *(specify below)* | | ☐ Yes ☐ No | Hepatitis |
| ☐ Yes ☐ No | Asthma | | ☐ Yes ☐ No | Kidney Condition |
| ☐ Yes ☐ No | Autism | | ☐ Yes ☐ No | Liver Condition |
| ☐ Yes ☐ No | Blood Disorder | | ☐ Yes ☐ No | Mental Disability |
| ☐ Yes ☐ No | Cancer | | ☐ Yes ☐ No | Physical Disability |
| ☐ Yes ☐ No | Cerebral Palsy | | ☐ Yes ☐ No | Sickle Cell |
| ☐ Yes ☐ No | Diabetes | | ☐ Yes ☐ No | Seizures |
| ☐ Yes ☐ No | Down's Syndrome | | ☐ Yes ☐ No | Special Needs (specify below) |
| ☐ Yes ☐ No | Emotional Problems | | ☐ Yes ☐ No | Speech Problems |
| ☐ Yes ☐ No | Epilepsy | | ☐ Yes ☐ No | Stomach/GI Disease |
| ☐ Yes ☐ No | Eye problems | | ☐ Yes ☐ No | Tuberculosis |
| ☐ Yes ☐ No | Fainting | | ☐ Yes ☐ No | Other: ____________________ |

If you checked yes on any of the above, please explain: ______________________________________________

_____________________________________________________________________________________

**PLEASE CHECK IF YOUR CHILD IS ALLERGIC TO ANY OF THE FOLLOWING:**

☐ latex ☐ metal ☐ acrylic ☐ local anesthesia ☐ penicillin ☐ aspirin ☐ other: __________________

## AUTHORIZATION STATEMENTS

I do hereby authorize Dr. Cumbus, Dr. Isherwood and their staff of Dentistry for Children, PA to provide my child with diagnostic and therapeutic procedures, including dental x-rays and photographs, as may be necessary for proper dental care. *(please initial)* ___________

I do hereby understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment by using praise, explanation, and demonstration of procedures and instruments using variable voice tones. I authorize this Dental Office to administer such medication, including the use of nitrous oxide ("laughing gas"), which is a mild sedative that is inhaled to reduce anxiety. *(please initial)* ______________

I do hereby authorize payment directly to this Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and that any estimate given to me is not guaranteed. I authorize the release of any information relative to all claims. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama or any other state. *(please initial)* ______________

I acknowledge that I have read your Notice of Privacy Practices in accordance with The Health Insurance Portability & Accountability act of 1996 (HIPAA), and have been offered a copy of it. *(please initial)* ______________

The information on this page, including the medical history, is correct to the best of my knowledge. I understand that if any of the above information changes, including medical history, that it is my responsibility to inform this Dental Office.

_______________________________________________ ____________________

*Signature of (circle one): Mother Father Grandparent Guardian* *Date*