shine
PEDIATRIC DENTISTRY

Tell Us About Your Child

Child's Name: _____ Nickname: _____
Last *First* *MI*

Child's Birthdate: _____ Child's Age: _____ Gender: _____

School: _____ Grade: _____

Child's Home Address: _____
Street *City* *State* *Zip*

What is the primary reason for today's visit? _____

How did you hear about us? (Check the box that applies)

- ☐ Drive-by/Walk-in
- ☐ Google/Search
- ☐ Insurance Directory
- ☐ Social Media
- ☐ Review Website
- ☐ Other
- ☐ Referred by patient? If so, please list their name: _____
- ☐ Referred by Pediatrician or dentist? If so, please list their name: _____

Dental History

Is this your child's first dental visit? ☐ Yes ☐ No

Is your child currently in pain? ☐ Yes ☐ No Has your child experienced problems with previous dental treatment? ☐ Yes ☐ No

If so, explain: _____

Previous dentist: _____ Date of last visit: _____ Date of last x-ray: _____

Why did you leave your previous dentist? _____

Have there been any injuries to your child's teeth or jaws? ☐ Yes ☐ No

Does your child take fluoride vitamins or drink fluoridated water? ☐ Yes ☐ No

Has your child been seen by an orthodontist? ☐ Yes ☐ No Who? _____

Does / did your child have any of the following habits: *(check the boxes that apply)*

- ☐ Breast fed
- ☐ Jaw pain
- ☐ Nursing bottle habits
- ☐ Thumb / finger sucking
- ☐ Chewing on objects
- ☐ Lip sucking / nail biting
- ☐ Pacifier
- ☐ Tongue / cheek biting
- ☐ Clenching / grinding teeth
- ☐ Mouth breather
- ☐ Sippy cup
- ☐ Tongue thrust

Medical History

Child's physician: _____ Phone: _____ Date of last visit: _____

Is your child currently under the care of a physician ☐ Yes ☐ No Please explain: _____

Does your child have social / personality / temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are immunizations current?** ☐ Yes ☐ No

Please list all medication and dosage that your child is currently taking: _____

Please list all drugs and / or things that cause your child allergic reactions: _____

Hospitalizations : _____

Operations: _____

Anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Has your child had / experienced any of the following: *(check the boxes that apply)*

- ☐ Abnormal bleeding
- ☐ ADD / ADHD
- ☐ AIDS / HIV +
- ☐ Anemia
- ☐ Asthma
- ☐ Autism Spectrum
- ☐ Auto-immune Disease
- ☐ Blood Disorder
- ☐ Breathing / Lung problems
- ☐ Cancer / Tumors
- ☐ Celiac disease
- ☐ Cerebral palsy
- ☐ Congenital birth defect
- ☐ Diabetes
- ☐ Down syndrome
- ☐ Endocrine system disorders
- ☐ Epilepsy / Seizures
- ☐ Frequent headaches
- ☐ Frequent infections
- ☐ Heart condition / Murmur
- ☐ Hearing Problems
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Low blood pressure
- ☐ Lupus
- ☐ Mental delays
- ☐ Physical delays
- ☐ Rheumatic fever
- ☐ Sight disorders
- ☐ Social delays
- ☐ Speech Delay
- ☐ Stomach / GI disease
- ☐ Tuberculosis (TB)

Please discuss any serious medical problems your child experiences, now or in the past: _____

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Supplemental Questions for Ages 12+:

Has your child experienced puberty? ☐ Yes ☐ No
Is your child pregnant or nursing? ☐ Yes ☐ No
Is your child on birth control? ☐ Yes ☐ No

Legal Guardian's Information

Legal Guardian #1 Email: _____

Name: _____ Birthdate: _____ Relationship to Child: _____

Cell Phone: _____ Alt Phone: _____ Additional Notes _____

Legal Guardian #2 Email: _____

Name: _____ Birthdate: _____ Relationship to Child: _____

Cell Phone: _____ Alt Phone: _____ _____

Emergency Contact: _____ Address: _____ Phone: _____

Insurance Information

Is your child covered by a dental insurance plan? ☐ Yes ☐ No

Primary Insurance

Insurance Co. Name: _____ Phone #: _____ Group #: _____
Street / PO Box *Plan, Local, or Policy Number*

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Birthdate: _____ Subscriber's ID #: _____ Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone #: _____ Group #: _____
Street / PO Box *Plan, Local, or Policy Number*

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Birthdate: _____ Subscriber's ID #: _____ Employer: _____

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status

Signature_____Date_____

Consent for Dental Treatment

I request and authorize Dr. Briney and her staff to provide my child with a comprehensive examination and prescribe X-rays that may be considered necessary to diagnose and/or treat my child's dental condition. Thereafter, I will be presented the treatment recommendations, risks, benefits and options to make informed decisions about my child's care. At that time, I request and authorize Dr. Briney and her staff to complete the accepted treatment for my child.

Signature_____Date_____