north scottsdale pediatric dentistry

Date_____

Patient Information

Last Name_____ First Name_____ Middle Initial_____ Sex_____

Prefers to be called_____ Date of Birth____/____/____ Age (years)_____

Address_____

City_____ State_____ Zip_____ Home Telephone_____

Siblings:(birthdays)_____

Parental Information

Mother

Name_____

Date of Birth____/____/____ SS#_____

Cell_____

Email Address_____

□ Single □ Married □ Widowed

□ Separated □ Divorced □ Guardian

Employer_____

Employer Phone_____

Complete if different:

Home Address_____

City_____ State_____ Zip_____

Home Telephone_____

Father

Name_____

Date of Birth____/____/____ SS#_____

Cell_____

Email Address_____

□ Single □ Married □ Widowed

□ Separated □ Divorced □ Guardian

Employer_____

Employer Phone_____

Complete if different:

Home Address_____

City_____ State_____ Zip_____

Home Telephone_____

Dental Insurance

(Please provide your insurance card to the receptionist)

Primary Insurance

Insurance Company_____

Insurance Telephone_____

Policy#_____ Group#_____

Policy Holder's Name_____

Relationship to Patient_____

Secondary Insurance

Insurance Company_____

Insurance Telephone_____

Policy#_____ Group#_____

Policy Holder's Name_____

Relationship to Patient_____

Referral Information

Who may we thank for your referral?_____

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Date_____

Child's name_____ Birth date_____ Sex_____

Child's pediatrician/physician_____ Physician Telephone_____

Medical History

GROWTH AND DEVELOPMENT

Any learning, behavioral, excessive nervousness or communication problems?	☐ No	☐ Yes
Has child had psychological counseling or is counseling being considered for the near future?	☐ No	☐ Yes
Were there any complications during pregnancy or was child premature at birth?	☐ No	☐ Yes
Any problems with physical growth?	☐ No	☐ Yes

CENTRAL NERVOUS SYSTEM

Any history of cerebral palsy, seizures, convulsions, fainting or loss of consciousness?	☐ No	☐ Yes
Any history of injury to the head?	☐ No	☐ Yes
Any sensory disorders?	☐ No	☐ Yes

CARDIOVASCULAR SYSTEM

Any history of congenital heart disease, heart murmur, or heart damage from rheumatic fever?	☐ No	☐ Yes
Has any heart surgery been done or recommended?	☐ No	☐ Yes
Any history of chest pains or high blood pressure?	☐ No	☐ Yes

HEMATOPOIETIC AND LYMPHATIC SYSTEM

Has your child ever had a blood transfusion?	☐ No	☐ Yes
Any history of anemia or sickle cell disease?	☐ No	☐ Yes
Does your child bruise easily, have frequent nosebleeds, or bleed easily from small cuts?	☐ No	☐ Yes

RESPIRATORY SYSTEM

Any history of pneumonia, cystic fibrosis, asthma, shortness of breath of difficulty in breathing?	☐ No	☐ Yes

GASTROINTESTINAL SYSTEM

Any history of stomach, intestinal or liver problems?	☐ No	☐ Yes
Any history of hepatitis or jaundice?	☐ No	☐ Yes
Any history of eating disorders, such as anorexia nervosa or bulimia?	☐ No	☐ Yes
Any history of unintentional weight loss?	☐ No	☐ Yes

GENITOURINARY SYSTEM

Any history of urinary tract infections, bladder or kidney problems	☐ No	☐ Yes
Is the patient pregnant or possibly pregnant?	☐ No	☐ Yes

ENDOCRINE SYSTEM

Any history of diabetes?	☐ No	☐ Yes
Any history of thyroid disorders or other glandular disorders	☐ No	☐ Yes

SKIN

Any history of skin problems?	☐ No	☐ Yes
Any history of cold sores (herpes) or canker sores (aphthae)	☐ No	☐ Yes

EXTREMITIES

Any limitations of use of arms or legs?	☐ No	☐ Yes
Any arthritis, joint bleeding, joint replacement, or other joint problems?	☐ No	☐ Yes
Any problems with muscle weakness or muscular dystrophy?	☐ No	☐ Yes

MEDICATIONS

Is your child currently taking any medication (prescription or non prescription medicine)?	☐ No	☐ Yes

Drug	Dose	Frequency	Reason

1. Is your child's general health good at this time? □ Yes □ No
2. Is a physician treating your child now for a specific illness? □ Yes □ No
   If so, please explain_____
3. Is your child allergic to any medications? □ Yes □ No
   If so, please list?_____
4. Does your child have any allergies? □ Yes □ No If so, please describe_____
5. Has your child ever been hospitalized? □ Yes □ No
   If so, when?_____For what reason?_____
6 Are all immunizations up to date? □ Yes □ No
7. Please check any of the following that your child has now or has been exposed to in the past.
   HIV/AIDS □ Yes □ No Lead poisoning □ Yes □ No Tuberculosis □ Yes □ No
   Substance Abuse □ Yes □ No Leukemia □ Yes □ No Child Abuse □ Yes □ No
8. Is there anything else regarding your child's physical, mental, or emotional health that you feel we should know? □ Yes □ No If so, please describe_____

Dental History

1. Is this the first dental visit? □ Yes □ No Previous Dentist _____
   Date of last dental visit?_____ Reason for visit?_____Date of last x-rays_____
2. What concerns you most about your child's teeth?

   _____

   Does your child ever have any dental pain? □ Yes □ No If yes, please describe.

   _____

   Has your child experienced any negative medical or dental care? □ Yes □ No If yes, please describe.

   _____

   How would you describe your child's temperament?_____
   How do you think your child will react to dental treatment?_____
3. Does your child have any of the following habits? □ Thumb/ Finger sucking □ Nail biting
   □ Lip sucking □ Tooth grinding □ Pacifier □ Mouth breathing □ Nursing bottle
   □ Nursing at bedtime □ Sippy cup □ None □ Other_____
4. How often does your child brush per day?_____
   Who brushes your child's teeth?_____
5. Has the child received any fluoride treatment?_____
6. Have your child's teeth ever been injured? □ Yes □ No
   If yes, please describe_____

I acknowledge that the information provided on this form is accurate. I hereby give permission to North Scottsdale Pediatric Dentistry to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, topical and local anesthetic (injections), voice control and radiographs (x-rays). Whoever accompanies this child on subsequent visits has my express permission to consent to treatment.

Signature of Legal Guardian_____**Date**_____

We accept assignment of some insurance plans. Your insurance policy is a contract between you, your employer, and the insurance company; our relationship is with you and your child and not the insurance company. All charges incurred are charged directly to you and you are personally responsible for payment. We understand that special circumstances may occur and encourage you to communicate any difficulties in the management of your account.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO NORTH SCOTTSDALE PEDIATRIC DENTISTRY FOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

*x*_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of North Scottsdale Pediatric Dentistry Notice of Privacy Practices

_____

Please Print Name

_____

Signature

_____

Date