PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

Date_____

Patient's **First/Last** Name _____Nickname _____

Age _____ Date of Birth _____ Sex ____ School _____

Address _____

City, State, Zip _____ _____Home Phone_____

Fathers Name _____Work Phone_____

Mothers Name_____ Work Phone_____

Email address_____ Cell Phone_____

Siblings Names and Ages _____

Fathers S. S # _____ Mothers S. S #_____

Nanny's Name _____

Does your nanny have your permission to consent to dental treatment for your child in your absence? Yes____ No_____ Comment _____

Child's Physician _____ Phone # _____

Pharmacy _____ Phone# _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

Person responsible for child's financial support _____

Reason for bringing child to the dentist _____

DENTAL INSURANCE

Dental Coverage: _____ Y_____ N

Insurance Co. Name:_____

Insurance Co. Address:_____

Insurance Co. Phone #: (_____)_____

Group # (Plan, Local or Policy #):_____

Insured's Name:_____ Relation:_____

Insured's Birthdate:____/_____/_____ Insured's ID#:_____

Insured's Employer:_____

History

1. Is a physician treating your child at this time? ◯Y ◯N
2. Date of child's last physical _____
3. Has your child ever been a patient in a hospital? ◯Y ◯N
4. Has your child ever received general anesthesia or sedation? ◯Y ◯N
5. Is your child allergic to anything? (Medicine, food) ◯Y ◯N
6. Is your child taking any medication at this time? ◯Y ◯N

   If yes, what? _____
7. Has your child ever had a blood transfusion? ◯Y ◯N
8. Does your child smoke or use tobacco products? ◯Y ◯N
9. Has a dentist before ever seen your child? ◯Y ◯N

   Date last seen? _____ Name of dentist? _____
10. Has your child ever received fluoride in any form? ◯Y ◯N
11. Does your child suck his/her thumb or fingers? ◯Y ◯N
12. Are your child's teeth brushed once or more a day? ◯Y ◯N
13. At what age did your child stop bottle/breast feeding? _____

Has this child ever had any treatment for any of the following?

Blood-Circulatory ☐ Gastrointestinal (stomach) ☐ Muscles ☐
Bones ☐ Kidney-Bladder ☐ Nervous System ☐
Endocrine Glands ☐ Heart ☐ Skin ☐ Liver ☐
Eyes, Ears, Nose, Throat ☐ Tonsils/Adenoids ☐

This child has NOT had any treatment for the above _____

Has this child ever been diagnosed as having the following conditions?

AIDS ☐ Anemia ☐ Allergy ☐ Arthritis ☐ Asthma ☐
Autism ☐ Brain Injury ☐ Bronchitis ☐ Cancer ☐
Cerebral Palsy ☐ Chicken Pox ☐ Cleft Lip/Plate ☐
Convulsions/Seizures ☐ Diabetes ☐ Diphtheria ☐ Drug/Alcohol Abuse ☐
Epilepsy ☐ Eye Problems ☐ Excessive Bleeding Problem ☐ Fainting ☐
Hearing Loss ☐ Heart Disease ☐ Hemophilia ☐ Hepatitis Type A/B ☐
Jaundice ☐ Leukemia ☐ Measles ☐ Mental Retardation ☐ Mumps ☐

Mouth Breathing ☐ Nutritional Deficiency ☐ Veneral Disease ☐
Whooping Cough ☐.

This child has never been diagnosed as having any of the above conditions _____

Is there anything else that you think we should know about your child?
_____

_____

I certify that I have read and understand the above questions. I will not hold Dr. Lodolini/Dr.Bianchi, or any member of her staff; responsible for any errors or omissions I may have made in the completion if this form.

_____ _____ _____
Signature of person completing form Relationship to patient Date

Medical Alert:

PEDIATRIC DENTISTRY CONSENT FOR DENTAL PROCEDURE AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it. After an oral examination and radiographs, Dr. Lodolini or Dr. Bianchi will explain to you what your child's dental needs are. The appropriate treatment plan, available alternatives, and number of appointments needed will be discussed with you.

1. Radiographs
2. Cleaning of teeth and Fluoride treatment.
3. Sealants
4. Local anesthesia to numb the teeth and tissues.
5. Treatment of diseased or injured teeth with dental restorations (fillings).
6. Removal of one or more teeth.
7. Treatment of diseased or injured oral tissues (hard and/or soft).
8. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities

I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask questions I might have, and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand further that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that I am free to withdraw my consent to treatment at any time and that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name _____

Signature of Parent of Guardian _____Date _____

Relationship to Patient _____

I certify that I explained the above procedures to the parent or legal guardian before requesting their signature

_____ _____

Signature of Dentists Date

TO WHOM MAY WE SEND THANKS FOR REFERRING YOU TO OUR PRACTICE.

NAME _____

ADDRESS: _____