Date_____

Patient's Name_____ Birth Date_____ Age_____
Nickname_____ Sex (Circle one) F M Other Patient's Phone #_____
Address_____
(Street) (City) (State) (Zip code)
Home Phone # (_____)_____ Name & Ages of Siblings_____
Parent #1: Name (Mr., Mrs., Ms., Dr.)_____ Social Security #_____ DOB_____
Parent #1 Employer_____ Work Ph. # (___)_____ Mobile (_____)_____
Parent #2 Name (Mr., Mrs., Ms., Dr.)_____ Social Security #_____ DOB_____
Parent #2 Employer_____ Work Ph. # (___)_____ Mobile (_____)_____

Who has legal custody of patient?_____ Patient lives with: Mother Father Both Other_____
Please provide the email address(es) of those who would like to receive appointment confirmation emails:
Email Address:_____ Mother Father Both Other_____
Email Address:_____ Mother Father Both Other_____
Pediatrician's Name: _____ Phone# (_____)_____ Date of last exam_____
May we send an oral health update to your child's physician? __Yes ___No
Preferred Pharmacy_____ Address_____ Phone# (_____)_____
How did you hear about our office: ___Internet Search _____Website _____Facebook/Instagram __Magazine Ad
_____Physician or Dentist ___Parent in our practice_____ _____Other _____
What is the reason for today's visit?_____

Yes	**No**	**Health History**
_____	_____	Has your child ever had a health problem? Please explain_____
_____	_____	Has your child ever been hospitalized? Please give reason and dates_____
_____	_____	Is your child allergic to anything?_____
_____	_____	Is your child currently taking any medications? Please give medication and reason _____
_____	_____	Were there any problems at birth?_____
_____	_____	Will someone other than a legal guardian be bringing your child to their appointment?_____

Do you consider your child to be: _____Advanced _____Progressing Normally ___Delayed _____Other_____

Please check if your child has been treated for any of the following:

_____Acid Reflux	_____Cancer	_____Frequent Infections	_____Light Sensitivity	_____Speech Problems
_____ADHD/ADD	_____Canker Sores	_____Growth Issues	_____Learning Differences	_____Stomach Issues
_____AIDS/HIV	_____Cold Sores	_____Headaches	_____Light Sensitivity	_____Thyroid Disorder
_____Anemia	_____Cerebral Palsy	_____Hearing Problems	_____Liver Disease	_____Ulcer
_____Anxiety	_____Cleft Lip/Palate	_____Heart Disease	_____Neurological Problems	___Vision Problems
_____Asthma	_____Cystic Fibrosis	_____Heart Murmur	_____Psychiatric Problems	
_____Autism Spectrum	_____Depression	_____Hepatitis A, B or C	_____Respiratory	
_____Autoimmune Disorder	___Diabetes	_____High Blood Pressure	_____Seasonal Allergies	
_____Behavioral Issues	_____Eating Disorder	_____Joint Problems	_____Sensory Disorder	
_____Bladder/Kidney	_____Epilepsy/Seizures	Latex Allergy	_____Sickle Cell	
_____Bleeding/Transfusion	____Food Allergies	_____Medication Allergies_____		

Adolescents: ____STD ___Substance Abuse, Alcoholism, Drug Addiction _____Pregnancy or Nursing ___Tobacco Use (Vaping/Smoking)

Does your child have any disease, condition, syndrome or issue not listed here?_____

_____

Yes **No** **Dental History**

_____ _____ Has your child ever been seen by a dentist? Name of Dentist_____

Date of Last Visit_____ Dentist's Phone # (____)_____

_____ _____ Has your child experienced any unfavorable reaction from previous dental care?

If yes, please explain._____

_____ _____Does your child suck a: _____Thumb _____Finger(s)_____ Pacifier _____Other

_____ _____ Does your child snore during sleep or stop breathing during sleep?_____

_____ _____ Has your child ever had problems with their jaw joint (TMJ)?_____

_____ _____Has your child had any recent injuries to the mouth or teeth? _____

_____ _____ Is your child in any dental discomfort?_____

_____ _____ How often does your child brush/floss?_____

_____ _____ Has your child ever had Nitrous Oxide (Laughing Gas), if yes did they have an unfavorable reaction?_____

Please check if your child is currently having problems with any of the following:

_____Cavities _____Toothache _____Sensitive Teeth _____Color of Teeth _____Trauma

_____Gum Infection _____Crowded or Crooked Teeth _____Eruption Problems

_____Pain with Chewing _____Grinding Teeth _____TMJ Pain

_____Jaw or Joint Noise _____Other_____

How cooperative do you feel your child will be for this appointment?

_____Well behaved _____Anxious _____Uncooperative _____Unsure Comments:_____

_____

Yes **No** **Fluoride History**

_____ _____ Is your drinking water fluoridated? (Your water is fluoridated if you pay a water bill.)

_____ _____ Do you use well water in your home? If yes, has it been analyzed for fluoride? Yes / No

_____ _____ Does your child use a fluoride toothpaste?

_____ _____ Do you give your child any other form of fluoride? What?_____

Consent of Dental Treatment

I request and authorize River Road Pediatric Dentistry to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the doctor examining my child to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic & academic purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The dentists will provide an environment to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

Signature_____ Relationship to Patient_____Date_____

Payment Policy

I will be responsible for any charges incurred on this child for dental treatment. I understand that by failing to make payments to River Road Pediatric Dentistry my account can be turned over to a collection agency. River Road Pediatric Dentistry will no longer provide dental care for my child 30 days after turn over. In cases of divorce, the custodial parent is responsible for any charges incurred.

Signature_____ Relationship to Patient _____Date_____

Notice Of Privacy Practices

I have been provided with River Road Pediatric Dentistry Notice of Privacy Practices that provides a complete description of their policy on the use of disclosure of protected health information.

Signature_____Relationship to Patient_____ Date_____