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_____