WELCOME KIDS!

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

www.mykiddsmiles.com fredpedo@mykiddsmiles.com Tel: (301) 668-2662 Fax: 301-663-0971
7360 Guilford Dr, Suite 102 Frederick, Maryland 21704

PEDIATRIC Dental Center of Frederick

Tell Us About Your Child

Today's Date: ___/___/___

Child's Name:
Last First Middle

Child's Birth date: ___/___/___ Child's Age:

Nickname/Preferred name:

Preferred Gender Pro-noun: _____

School: Grade: _____

Hobbies: _____

Social Security #: _____ Child's Home #:( )_____

Child's Home Address:

#Apt. / Condo

City State Zip Code

Gender:
- ❑ *Male*
- ❑ *Female*
- ❑ *Unknown*

General Information

Who is accompanying the child today? _____

Name: Relation:

Do you have legal custody of the child? Yes No

Who may we thank for referring you?

Other siblings: _____

Previous/ Present Dentist: Last visit date: _____

Dentist Phone # : ( )

Relative or friend not living with you: _____

Name: Phone #: ( ) _____

Address: _____
City State Zip Code

Parent / Guardian Information

Is anyone else permitted to bring the patient to their appointments or make decisions regarding treatment? (Must be over 18 and provide identification at each visit):

Name: _____ Relationship: _____ Bring to appointment only: Y / N Treatment/ financial decisions: Y / N

Name: _____ Relationship: _____ Bring to appointment only: Y / N Treatment/ financial decisions: Y / N

1st Person responsible for Account:

Relationship to patient: _____

Gender (please circle): Male Female Unknown

Name: Birth date: ____/____/____

Address: (if different than Child's): Hm#: ( ) _____

SS #: DL#: _____

Wk #: ( ) Ext: _____ Cell/other #: ( )

E-mail:

Employer: _____

Employer's Address: _____

City State Zip Code

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address:

City State Zip Code

Insurance Phone #: ( ) Group #

(Plan, Local or Policy #):

2nd Person responsible for Account:

Relationship to patient: _____

Gender (please circle): Male Female Unknown

Name: _____ Birth date: ____/____/____

Address: (if different than Child's): Hm#: ( ) _____

SS #: _____ DL#: _____

Wk #: ( ) Ext: _____ Cell/other #: ( ) _____

E-mail:

Employer:

Employer's Address:

City State Zip Code

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name:

Insurance Address: _____

City State Zip Code

Insurance Phone #: ( ) Group #

(Plan, Local or Policy #):

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature of Parent or Guardian Date

Dental History

Why did you bring the child to see the dentist today?

_____

Y N Has the child ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin) If so, when?

Y N Is the child currently in pain? Does the child require antibiotics before dental treatment?

Y N Has the child ever had a serious/difficult problem associated with dental work?

Y N Is the child's water fluoridated?

Y N Is the child taking fluoridated supplements?

Y N Is the childs water, Well water?

Y N **Has the child ever had any pain/tenderness in in his/her jaw joint (TMJ/TMD)?**

Y N Does the child brush his/her teeth daily?

Y N Does the child floss his/her teeth daily?

Child / Parent Who brushes/ flosses the childs teeth?

Child's Physician:_____

Phone #: ( )_____ Date of Last Visit: _____

Y N Is the child currently under the care of a physician?

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list any drugs that the child is currently taking:

_____

Please list all drugs that the child is allergic to:

_____

_____

Y N Allergic to Latex

Y N Allergic to Nickel

Y N Allergic to Metals

Y N Allergic to Plastic

Medical History

Has the child experienced any of the following medical problems?

Y N Abnormal Bleeding/Hemophilia
Y N ADD/ADHD
Y N Autism
Y N Sensory Sensitivity (details please)

_____

_____

Y N AIDS/HIV+
Y N Anemia
Y N Any Hospital Stays/Operations?
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but Neg.
Y N Dental Phobia/ Anxiety
Y N Skin Rash

Y N Handicaps/Disabilities
Y N Hearing impairment
Y N Deaf
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Tuberculosis (TB)
Y N Anxiety/ Depression

Y N Are the child's immunizations current?

Y N Is there anything you would like to discuss with the Doctor in Private?

Please discuss any serious medical problems the child experiences/ed:

_____

Does/did the child experience any of the following?

Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting

Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/finger Sucking
Y N Tongue/Cheek Sucking
Y N Tongue Thrust
Y N Used Pacifier

OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Responsible Party: Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_____ _____

Signature of Dentist Date

Dentist's Comments: _____

_____

Medical History Update

Has there been any change in your child's health status since their last visit? ❑ Yes ❑ No

If Yes, Please explain: _____

_____

Has there been any change in your child's health status since their last visit? ❑ Yes ❑ No

If Yes, Please explain: _____

_____

_____ _____

Parent /Guardian Signature Date

_____ _____

Dentist Signature Date

_____ _____

Parent /Guardian Signature Date

_____ _____

Dentist Signature Date