Welcome to

Madison Pediatric Dental and Orthodontics

Producing Great Smiles!

Dr. Douglas Wilson * Dr. Thomas Wenham * Dr. Grace Wenham 100 River Place, Suite 110 Madison, WI 53716 (608) 222-6160 Office (608) 222-6248 Fax



Date

Child's Name		Date			
Last First Child's Date of Birth	Tell us about your child:	Nickname	Child's gender 1	vi i	
Child's Date of Birth Child's Age Child's Home phone#	Last First	THE RIGHT	_ Gima o Beilaei i	35	
Whom may we thank for referring your child?	Child's Date of Birth/ Child's Age	Child's Home phone#			
Whom may we thank for referring your child? Other family members seen by us Who is accompanying the child today? Name: Parent Information: Name Mother Father Guardian Foster Parent Date of Birth Mother Father Guardian Foster Parent Date of Birth Home Address Address City State Up Cellular Phone # (Child's Home Address			71.	
Other family members seen by us	Whom may we thank for referring your child?		State	ДÞ	
Who is accompanying the child today? Name:	Other family members seen by us				
Name	Who is accompanying the child today? Name:	Relation	ship		
Mother Father Guardian Foster Parent Date of Birth / / SS# Date of Birth / / SS# Home Address	and the contract	N			
Date of Birth		Mother Father Gu	ardian Foster Pare	nt	
Home Address Address Address City State Zip Cellular Phone # (
Address	Date of Birth// SS#		SS#	(4 .0)	
City State Zip Home # (Home	Home			
Home # (Address	Address		_	
Home # (City State Zip	City State			
Cellular Phone # (Home # ()	Home # ()	V-124-1	e e	
Employer	Cellular Phone # ()	Cellular Phone # ()			
Is this your child's first visit to the dentist? Y N If No, previous dentist name?		Email	9 B		
Is this your child's first visit to the dentist? Y N If No, previous dentist name?	Employer	Employer			
Is this your child's first visit to the dentist? Y N If No, previous dentist name?	Work # () Ext	Work # ()	Ext		
Is dental floss used? Y N Has your child ever had a problem associated with previous dental treatment? Y N If yes, Please explain	Dental History:				
Is dental floss used? Y N Has your child ever had a problem associated with previous dental treatment? Y N If yes, Please explain	teatterness at the free state of a decade 2 V Al				
Has your child ever had a problem associated with previous dental treatment? Y N If yes, Please explain		Is dental flore used?		v	N
Has your child ever had a problem associated with previous dental treatment? Y N If Yes, Please explain	[[[- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ner dav		
dental treatment? Y N If yes, Please explain	Last visit date	How Ottent	iet day		
dental treatment? Y N If yes, Please explain	Has your child ever had a problem associated with previous	Does your child take fluoride st	applement?	Y	N
Have missing teeth been replaced? Y N Has your child had any injuries to their mouth, teeth or face? Y N If yes, please explain					
Has your child had any injuries to their mouth, teeth or face? Y N If yes, please explain	If yes, Please explain	- 1001 日本的 Xで			
face? Y N If yes, please explain		Have missing teeth been replace	:ed?	Y	N
face? Y N If yes, please explain	Has your child had any injuries to their mouth, teeth or	Orthodontic appliances worn	ow or ever?	v	N
If yes, please explain		orthodolitic appliances from the	on or ever.	•	•••
☐ Lip sucking / Biting ☐ Nail Biting ☐ Currently breast feeding ☐ Currently using a bottle ☐ Thumb / Finger sucking ☐ Do you assist your child with brushing teeth? ☐ Y N		Any unusual speech habits?		Υ	N
☐ Lip sucking / Biting ☐ Nail Biting ☐ Currently breast feeding ☐ Currently using a bottle ☐ Thumb / Finger sucking ☐ Do you assist your child with brushing teeth? ☐ Y N	Does your child have any of the following oral habits?				
□ Nail Biting □ Currently breast feeding □ Currently using a bottle □ Thumb / Finger sucking □ Do you assist your child with brushing teeth? □ Nail Biting Please list another other dental concerns you may have: □ Thumb / Finger sucking					_
Currently breast feeding Currently using a bottle Thumb / Finger sucking Do you assist your child with brushing teeth? Y N		Please list another other denta	Concerns voir may		
☐ Currently using a bottle ☐ Thumb / Finger sucking Do you assist your child with brushing teeth? Y N	500.05 - (B) 5000000000000000000000000000000000000		and a second contract of the c		
☐ Thumb / Finger sucking Do you assist your child with brushing teeth? Y N					
Do you assist your child with brushing teeth? Y N					
HOW OTTER? Per day	Do you assist your child with brushing teeth? Y N How often? Per day				

Medical History:		201 N THE STATE OF	Primary Insurance Information:		
Has your child ever been diagnosed as having any of the			Insurance Co. Name		
following conditions? Check all that apply Y N		ig conditions? Check all that apply	Address		
		ADHD			
		AIDS/HIV+	Insurance Co. Phone# ()		
		Anemia	Group#		
		Asthma Triggered by:	Policy ID#		
		Autism	Policy Owner's Name		
	300	Cancer Type:	Relationship to child		
		Congenital Heart Defect	Policy Owner's Birth Date/		
		Diabetes	Policy Owners Employer		
	15-27-2	Epilepsy/Convulsions:			
		Seizures? Last date of seizure	Secondary Insurance Information:		
87.53	П	Hearing impairment	Insurance Co. Name		
	ī	Heart murmur	Address		
		Hemophilia/Bleeding disorder			
		STATE OF A STATE OF THE STATE O	Insurance Co. Phone# ()		
		Kidney/Liver condition	Group#		
		Special Needs	Policy ID#		
	ш.	Autism	Policy Owner's Name		
		Disabilities/Handicaps	Relationship to child		
		Physical or psychological development delay	Policy Owner's Birth Date/		
		Physical of psychological development delay	Policy Owners Employer		
	п	Tuberculosis	t oney officers employer		
		Pre-Med required for dental treatment	Third Insurance Information:		
	-	Reason			
	п	Other	Insurance Co. Name		
	ш	Other	Address		
Alla	raia	s (drug ,environmental or latex):	Insurance Co. Phone# ()		
Allei	gle		Group#		
-			Policy ID#		
-			Policy Owner's Name		
Current medications:		modiantiones	Relationship to child		
_			Policy Owners Employer		
Chile	d'e I	Physician			
		ame			
		(Last Physical Exam?			
Pho	пен	Last Physical Exami			
Clan	-4	re on file			
	_	ize the release of any information relating to			
		ent done on my child. I understand that and hereby	2000 HISTO Manageria de Cara d		
			The permission of the parent or legal guardian is		
authorize payment to Madison Pediatric Dental and Orthodontics from my group insurance benefits. HIPPA Lundontica & asknowledge the Notice of Privacy Practices			necessary for dental treatment of a minor.		
		ontics from my group insurance benefits.	The above information I have given is correct to the best of		
		etand C. acknowledge the Notice of Drivacy Practices	my knowledge and I understand it is my responsibility to		
I understand & acknowledge the Notice of Privacy Practices.		in a serious is written normicsion under	inform this office of any changes. I authorize the dental staff		
In addition my signature is written permission under		ion my signature is written permission under	to perform any and all necessary dental treatment my child		
Wisconsin law for the use of individuals dental records to			needs.		
carry out treatment & health information.					
Financial Policy					
Payment is due day of when non covered treatment is			Parent/Legal Guardian Date		
prov	vide	d. We accept cash, personal checks & major credit	Laterial rePational and		
cards. If needed we are willing to setup a payment					
arrangement. As a courtesy we will file a claim to your					
		ice. I understand and agree that I am ultimately			
resp	pon	sible for the balance on this account.			