

Welcome to Madison Pediatric Dental & Orthodontics
Producing Great Smiles!



**MADISON
PEDIATRIC
DENTAL & ORTHODONTICS**

Dr. Grace Wenham * Dr. Beth Blair * Dr. Nika Lustgarten * Dr. Thomas Wenham
220 W Broadway, Madison, WI 53716
(608)222-6160 office (608) 222-6248 fax kidsdental1@madped.com

Date: _____

Tell us about your child

Child's Legal Name: _____ Nickname: _____

last first middle
Child's Date of Birth ___ / ___ / ___ Child's Age: _____ Home Phone #: _____

Child's Home Address: _____

Birth Sex: M F Gender identity: _____ Preferred Pronouns: _____ Race/Ethnicity: _____

Primary Physician: _____ Phone: _____ Clinic Name: _____

Medical Specialists: _____ Phone: _____ Clinic Name: _____

Parent / Legal Guardian Information *please complete all that apply*

Mother Father Guardian Step-parent Foster-parent

Mother Father Guardian Step-parent Foster parent

Name _____

Name _____

Date of Birth ___ / ___ / ___ SS# _____

Date of Birth ___ / ___ / ___ SS# _____

Address _____

Address _____

city state zip

city state zip

Phone (____) _____

Phone (____) _____

home cell work

home cell work

Phone (____) _____

Phone (____) _____

home cell work

home cell work

Email _____

Email _____

Employer: _____

Employer: _____

Current Medications (*please list name, dose, frequency & date started*) _____

Has your child ever been hospitalized, had surgery or a significant injury or been treated in an emergency department? _____

Has your child ever had a reaction to or problems with an anesthetic? Describe _____

Has your child ever had a reaction or allergy to an antibiotic, other medication, sedative, food, metal, dye, latex etc.? List: _____

Does your child require an antibiotic pre-medication for dental treatment? Yes No

Has your child ever been diagnosed as having any of the following conditions?

Y	N		Y	N	
<input type="checkbox"/>	<input type="checkbox"/>	ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Frequent exposure to tobacco smoke
<input type="checkbox"/>	<input type="checkbox"/>	Adenoids Removed	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impairment
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV+	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	<input type="checkbox"/>	Anemia or sickle cell disease	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia or a bleeding disorder
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, wheezing, breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or liver problems
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/bladder problems
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect/ disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever or heart disease
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes, hyperglycemia, hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	Special Needs
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy, Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils Removed
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds/coughs or pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis

If you answered yes to any of the above, provide details here: _____

Is there any other significant medical history **pertaining to this child or his/her family** that the dentist should be told? Yes No If YES, please explain _____

What is your primary concern about your child's oral health? _____

Does your child have any of the following oral habits?

- Lip sucking / biting Currently breast feeding Nail biting
 Thumb/ finger sucking Currently using a bottle

How often does your child brush their teeth? _____ times per _____. Does someone help them brush? Yes No

How often does your child floss their teeth? _____ times per _____. Does someone help them floss? Yes No

What is the source of your drinking water at home? City/community supply Private well Bottled water

Please check all sources of fluoride your child receives:

- Drinking water Toothpaste Over-the counter rinse Prescription rinse/gel Prescription drops/tablets/vitamin
 Fluoride treatment in the dental office Fluoride varnish by pediatrician/other practitioner Other _____

How do you expect your child will respond to dental treatment? Very well Fairly well
 Somewhat poorly Very poorly

Is there anything else we should know before treating your child? Yes No

If YES, please explain _____

HIPAA: I understand and acknowledge the Notice of Privacy Practices. I authorize the release of any information relating to my child's dental treatment to those who have a need to know such as a pediatrician or other dental office.

Financial Policy: Payment is due the day of service. As a courtesy Madison Pediatric Dental & Orthodontics will file a claim to the insurance on file. I understand and hereby authorize Madison Pediatric Dental & Orthodontics to collect payment from my insurance on file. I understand and agree that I am ultimately responsible for the balance on the account.

Consent: Permission of the parent or legal guardian is required for dental treatment of a minor.

The information in this document is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes. I authorize Madison Pediatric Dental & Orthodontics, its Dentists and Staff to perform any and all necessary treatment my child needs.

Signature _____

Printed Name: _____ Relationship to Patient: _____ Date: _____