**Welcome to Madison Pediatric Dental & Orthodontics**
***Producing Great Smiles!***

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MADISON PEDIATRIC DENTAL & ORTHODONTICS

**Date:**

## Tell us about your child

Child's Legal Name: _____ Preferred Name: _____
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

Name _____

Date of Birth ___ / ___ / ___ SS# _____

Address _____

_____
*city state zip*

Phone (____) _____
❒ home ❒ cell ❒ work

Phone (____) _____
❒ home ❒ cell ❒ work

Email _____

Employer: _____

❒Mother ❒Father ❒Guardian ❒Step-parent ❒Foster parent

Name _____

Date of Birth ___ / ___ / ___ SS# _____

Address _____

_____
*city state zip*

Phone (____) _____
❒ home ❒ cell ❒ work

Phone (____) _____
❒ home ❒ cell ❒ work

Email _____

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 | |
|---|---|---|---|---|---|
| ❒ | ❒ | ADHD | ❒ | ❒ | Frequent exposure to tobacco smoke |
| ❒ | ❒ | Adenoids Removed | ❒ | ❒ | Hearing impairment |
| ❒ | ❒ | AIDS/HIV+ | ❒ | ❒ | Heart Murmur |
| ❒ | ❒ | Anemia or sickle cell disease | ❒ | ❒ | Hemophilia or a bleeding disorder |
| ❒ | ❒ | Asthma, wheezing, breathing problems | ❒ | ❒ | Hepatitis |
| ❒ | ❒ | Autism | ❒ | ❒ | Jaundice or liver problems |
| ❒ | ❒ | Cancer | ❒ | ❒ | Kidney/bladder problems |
| ❒ | ❒ | Congenital Heart Defect/ disease | ❒ | ❒ | Rheumatic fever or heart disease |
| ❒ | ❒ | Diabetes, hyperglycemia, hypoglycemia | ❒ | ❒ | Special Needs |
| ❒ | ❒ | Epilepsy, Convulsions | ❒ | ❒ | Tonsils Removed |
| ❒ | ❒ | Frequent colds/coughs or pneumonia | ❒ | ❒ | 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: _____