Welcome to

Madison Pediatric Dental and Orthodontics

Producing Great Smiles!

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www.madisonpediatricdental.com

Date

Tell us about your child:

Child's Name_____ Nickname_____ Child's gender M F
Last First

Child's Date of Birth____/____/_____ Child's Age_____ Child's Home phone# _____

Child's Home Address_____
City State Zip

Whom may we thank for referring your child? _____

Other family members seen by us_____

Who is accompanying the child today? Name: _____ Relationship _____

Parent Information:

Name_____
Mother Father Guardian Foster Parent

Date of Birth____/____/_____ SS#_____

Home Address_____

_____
City State Zip

Home # (_____) _____

Cellular Phone # (_____) _____

Email_____

Employer _____

Work # (_____) _____ Ext. _____

Name_____
Mother Father Guardian Foster Parent

Date of Birth____/____/_____ SS#_____

Home Address_____

_____
City State Zip

Home # (_____)_____

Cellular Phone # (_____)_____

Email_____

Employer _____

Work # (_____)_____ Ext. _____

Dental History:

Is this your child's first visit to the dentist? Y N

If No, previous dentist name? _____

Last visit date_____

Has your child ever had a problem associated with previous dental treatment? Y N

If yes, Please explain_____

_____

_____

Has your child had any injuries to their mouth, teeth or face? Y N

If yes, please explain_____

Does your child have any of the following oral habits?

- ☐ 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

How often? _____ Per day

Is dental floss used? Y N

How Often?_____ per day

Does your child take fluoride supplement? Y N

If Yes, what type?_____

Have missing teeth been replaced? Y N

Orthodontic appliances worn now or ever? Y N

Any unusual speech habits? Y N

_____

Please list any other dental concerns you may have:

_____

_____

_____

_____

(Continued on reverse side)

Medical History:

Has your child ever been diagnosed as having any of the following conditions? Check all that apply

Y N

- ☐ ☐ ADHD
- ☐ ☐ AIDS/HIV+
- ☐ ☐ Anemia
- ☐ ☐ Asthma Triggered by:_____
- ☐ ☐ Autism
- ☐ ☐ Cancer Type:_____
- ☐ ☐ Congenital Heart Defect
- ☐ ☐ Diabetes
- ☐ ☐ Epilepsy/Convulsions:
  Seizures? Last date of seizure_____
- ☐ ☐ Hearing impairment
- ☐ ☐ Heart murmur
- ☐ ☐ Hemophilia/Bleeding disorder
- ☐ ☐ Hepatitis
- ☐ ☐ Kidney/Liver condition
- ☐ ☐ Special Needs
  Autism
  Disabilities/Handicaps
  Physical or psychological development delay
  _____
- ☐ ☐ Tuberculosis
- ☐ ☐ **Pre-Med required for dental treatment**
  Reason_____
- ☐ ☐ Other_____
  _____

Allergies (drug ,environmental or latex):_____
_____
_____

Current medications:_____
_____
_____

Child's Physician_____
Clinic Name_____
Phone#(_____)_____ Last Physical Exam?_____

Primary Insurance Information:

Insurance Co. Name_____
Address_____
_____
Insurance Co. Phone# (_____)_____
Group#_____
Policy ID#_____
Policy Owner's Name_____
Relationship to child_____
Policy Owner's Birth Date_____/_____/_____
Policy Owners Employer_____

Secondary Insurance Information:

Insurance Co. Name_____
Address_____
_____
Insurance Co. Phone# (_____)_____
Group#_____
Policy ID#_____
Policy Owner's Name_____
Relationship to child_____
Policy Owner's Birth Date_____/_____/_____
Policy Owners Employer_____

Third Insurance Information:

Insurance Co. Name_____
Address_____
_____
Insurance Co. Phone# (_____)_____
Group#_____
Policy ID#_____
Policy Owner's Name_____
Relationship to child_____
Policy Owner's Birth Date_____/_____/_____
Policy Owners Employer_____

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