

Welcome to

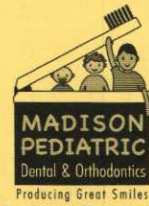
Madison Pediatric Dental and Orthodontics

Producing Great Smiles!

Dr. Grace Wenham * Dr. Beth Blair * Dr. Jennifer Chun * Dr. Thomas Wenham

100 River Place, Suite 110 Madison, WI 53716

(608) 222-6160 Office (608) 222-6248 Fax kidsdental1@madped.com



www.madisonpediatricdental.com

Date _____

Tell us about your child:

Child's Name _____ Last _____ First _____ Nickname _____ Child's gender M F

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.

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.

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.

Signature _____

Printed Name _____

Consent

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

Relationship to Patient _____

Date _____