STATESBORO Pediatric Dentistry

NEW PATIENT HISTORY FORM

PATIENT INFORMATION

Name _____ **Sex** ☐ m ☐ f
last first middle

Nickname _____ **Hobbies/Interests** _____

Date of Birth _____ **School Grade** _____

Siblings _____
names & ages

Home Address _____
city state zip

Primary Phone h / c / w _____ **Alternate Phone h / c / w** _____

GUARDIAN INFORMATION

_____ **Name** _____ **Marital Status: Married / Divorced / Single**
(relation to patient)

Phone _____ **Email** _____

_____ **Name** _____ **Marital Status: Married / Divorced / Single**
(relation to patient)

Phone _____ **Email** _____

Do These Individuals Live With The Patient? Yes ☐ No ☐

If No, Who Does The Patient Live With? _____

PATIENT HISTORY

Child's Physician: _____ **Date Of Last Visit:** _____

Name Of Practice: _____ **Phone Number:** _____

Are Immunizations Current? Yes ☐ No ☐

Is Your Child Under Medical Care At Present? Yes ☐ No ☐ If Yes, Please Explain: _____

medical

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS?

PLEASE CHECK OFF ALL THAT APPLY:

- ☐ add/adhd
- ☐ allergies
- ☐ anemia
- ☐ anxiety/depression
- ☐ emotional disturbances
- ☐ asthma
- ☐ acid reflux
- ☐ autism/asperger
- ☐ bleeding disorders
- ☐ cancers
- ☐ cerebral palsy
- ☐ cleft lip/palate
- ☐ high blood pressure
- ☐ genetic disorder
- ☐ down syndrome
- ☐ chronic sinus infections
- ☐ chronic ear infections
- ☐ cystic fibrosis
- ☐ seizures/epilepsy
- ☐ developmental delay
- ☐ diabetes
- ☐ hiv/aids
- ☐ hepatitis
- ☐ mental retardation
- ☐ learning disabilities
- ☐ sleep apnea
- ☐ enlarged tonsils
- ☐ snoring
- ☐ difficulty breathing
- ☐ heart disease
- ☐ heart murmur
- ☐ heart defects
- ☐ hemophilia
- ☐ kidney problems
- ☐ liver problems
- ☐ lung problems
- ☐ immune system problems
- ☐ psychiatric treatment
- ☐ speech/hearing issues
- ☐ birth defects
- ☐ premature birth
- ☐ arthiritis
- ☐ painful joints
- ☐ rheumatic fever
- ☐ sickle cell disease
- ☐ sickle cell trait
- ☐ tuberculosis
- ☐ neurological problems
- ☐ orthopedic problems
- ☐ eye problems

PATIENT HISTORY

medical (cont.)

Does your child have any other diseases, conditions, or syndromes not listed above? Yes ☐ No ☐

If Yes, Please Explain: _____

Is your child allergic to any food or medicine? Yes ☐ No ☐

If Yes, Please List: _____

Is your child taking any medicine? Yes ☐ No ☐

If Yes, Please List: _____

Has your child ever been sedated or had general anesthesia? Yes ☐ No ☐

If Yes, What For: _____

Has your child ever had surgery or been hospitalized? Yes ☐ No ☐

If Yes, Please Explain: _____

Is your child having any difficulties in school? Yes ☐ No ☐

If Yes, Please Explain: _____

Is there anything else we should know about your child? _____

Is there anything about your child you would like to discuss in private? Yes ☐ No ☐

PATIENT HISTORY

dental

Please check off reason(s) for seeking dental care:

☐ first examination ☐ routine check-up ☐ toothache or swelling ☐ cavities ☐ appearance of teeth ☐ crowding ☐ accident/injury

☐ other: _____

Has your child been to a dentist previously? Yes ☐ No ☐

When: _____ Where: _____

Were x-rays taken? Not Sure ☐ Yes ☐ No ☐

Does your child have any of the following habits?

☐ thumb/finger sucking ☐ mouth breathing ☐ pacifier ☐ snoring ☐ bottle/sippy cup ☐ lip sucking/biting ☐ grinding/clenching

What source of water does your child drink: ☐ City Water ☐ Bottled Water ☐ Well Water

Is your child breast fed or using a bottle/sippy cup? Yes ☐ No ☐

If No, What Age Did It Stop? _____

Frequency of tooth brushing? _____ **Flossing?** _____

Who does the brushing? (check all that apply) ☐ Child ☐ Parent/guardian

What type of toothpaste does your child use: ☐ Fluoride ☐ No Fluoride

How would you describe your child's temperament? (check all that apply)

☐ outgoing ☐ moody ☐ stubborn ☐ anxious ☐ frightened ☐ regular kid ☐ shy ☐ curious ☐ friendly ☐ high strung ☐ defiant ☐ cooperative

Has your child ever experienced any problems or complications due to dental care? Yes ☐ No ☐

If Yes, Please Explain: _____

HOW DID YOU FIND US?

☐ google/internet ☐ insurance ☐ direct mailer ☐ referred by a friend (name): _____ other: _____

THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I AUTHORIZE STATESBORO PEDIATRIC DENTISTRY TEAM TO COMPLETE A DENTAL EVALUATION, INCLUDING EXAMINATION, X-RAYS, PHOTOGRAPHS, CLEANING AND FLUORIDE TREATMENT WHEN NECESSARY AS STANDARD OF CARE TO PROPERLY DIAGNOSE AND RECORD ANY AND ALL DENTAL CONDITIONS (PLEASE CROSS OUT ANY TREATMENT THAT YOU DO NOT WANT PERFORMED.) I AUTHORIZE MY INSURANCE COMPANY TO PAY STATESBORO PEDIATRIC DENTISTRY ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I ALSO AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED WHETHER OR NOT IT IS COVERED BY MY INSURANCE, INCLUDING ALL LATE PAYMENT SERVICES CHARGES. THIS CONSENT IS TO REMAIN IN EFFECT FROM THE DATE INDICATED UNTIL CANCELLED IN WRITING.

Authorized Signature _____ Relationship To Child _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Statesboro Pediatric Dentistry Notice of Privacy Practices. Our notice provides information about how we may use and disclose your protected health information. We encourage you to review the notice carefully.

I acknowledge receipt of Statesboro Pediatric Dentistry Notice of Privacy Practices.

X _____

AUTHORIZED SIGNATURE

EMERGENCY CONTACT

IN THE EVENT OF AN EMERGENCY PLEASE CONTACT (OTHER THAN YOURSELF):

Name _____ **Relationship** _____ **Phone** _____

Name of nearest relative not living with child _____ **Phone** _____

INTERPRETERS SIGNATURE

_____

(Interpreter) **(Printed Name)**

OFFICE USE:

SBE prophylaxis required: Yes ☐ No ☐ Precautions: _____

Medical health reviewed by:

X _____

DOCTOR'S SIGNATURE AND DATE

A LEGAL GUARDIAN WHO WISHES TO HAVE THEIR CHILD BE ACCOMPANIED BY A PERSON OTHER THAN A LEGAL GUARDIAN, PLEASE COMPLETE THE SECTION BELOW.

POWER OF ATTORNEY

I, the undersigned, hereby authorize _____ **to bring in** _____ **to receive dental treatment.**

Signature Of Parent Or Guardian X _____ **Date** _____

I give permission to Statesboro Pediatric Dentistry to administer any necessary treatment in the event of a medical emergency.

Signature Of Parent Or Guardian X _____ **Date** _____

IF THE CHILD IS A WARD OF THE STATE OF GEORGIA, PLEASE COMPLETE THE SECTION BELOW.

CASE WORKER INFORMATION

Name: _____ **Office Name:** _____

Phone #: _____ **Fax #:** _____

Address: _____

Is the caseworker the legal guardian: ☐ Yes ☐ No

If no, who is the patient's legal guardian? _____