PEDIATRIC DENTAL ACQUAINTANCE FORM

Date _____

Demographic Information

Patient's Name _____ Name they would like to be called _____

Age _____ Birth date _____ Patient's Mobile # (___)_____ Sex (Circle one) F M

Address _____
(Street) (City) (State) (Zip Code)

Home Phone # (___)_____ Names & ages of siblings _____

Parent 1's Name _____ Social Security # _____ DOB _____

Parent 1's Employer _____ Work Phone # (___)_____ Mobile Phone # (___)_____

Parent 2's Name _____ Social Security # _____ DOB _____

Parent 2's Employer _____ Work Phone # (___)_____ Mobile Phone # (___)_____

Who has legal custody of patient? _____ Patient lives with: Mother Father Both Other _____

Please provide the email address(es) of those who would like to receive appointment confirmation emails:

Email Address: _____ (Mother / Father / Other_____)

Email Address: _____ (Mother / Father / Other_____)

Child's Physician _____ Phone # (____)_____ Date of last exam _____

Preferred Pharmacy _____ Address/Location _____ Phone (___)_____

How did you hear about our office: ☐ Internet/Website ☐ Friend_____ ☐ Physician/Dentist_____ ☐ Other _____

What is the reason for today's visit? _____

Health History

YES NO

___ ___ Has your child ever had a health problem? Please explain_____

___ ___ Has your child ever been hospitalized? Please give reason and dates_____

___ ___ Is your child allergic to anything?_____

___ ___ Is your child currently taking any medications? Please give medication and reason _____

_____

___ ___ Were there any problems at birth?_____

Please check if your child has been treated for any of the following:

___ Heart disease	___ Liver disease	___ Kidney disease	___ Bleeding/transfusion
___ Asthma	___ Anemia	___ Rheumatic fever	___ Seizures
___ Diabetes	___ Hepatitis	___ Cerebral palsy	___ Cleft lip/palate
___ AIDS	___ Depression	___ ADHD/ADD	___ Learning Disability
___ Speech/hearing	___ Other Problems (Please explain) _____		

Please check any Illnesses that your child has now, has recently been exposed to, or has had in the past:

___ Upper Respiratory Infection, Common Cold, Sinus Infection or Tonsillitis ___ HIV/AIDS ___ Scarlet Fever ___ TB

In regards to learning, do you consider your child to be: ___ advanced ___ progressing normally ___ delayed

Dental History

YES NO

___ ___ Has your child ever been seen by a dentist? Name of dentist____

Date of last visit ______________________________ Dentist's phone number_______________________

___ ___ Has your child experienced any unfavorable reaction from previous dental care?

If yes, please explain ____

___ ___ Does your child suck a: ☐ thumb ☐ finger(s) ☐ pacifier ☐ other _____________________

___ ___ Does your child have pain with chewing, yawning or wide opening? ______________________________________

___ ___ Does your child's jaw make noise and is pain associated with the sounds? ________________________________

Please check if your child is having problems with any of the following:

___ Cavities ___ Toothache ___ Teeth are sensitive ___ Color of teeth

___ Trauma ___ Gum infections ___ Orthodontics ___ Other __________

How cooperative do you feel your child will be for this appointment? ___ Well behaved ___ Anxious ___ Uncooperative

___Unsure ___ Other____

Fluoride History

YES NO

___ ___ Is your drinking water fluoridated? (Your water is fluoridated if you pay a "City of Durham" or "OWASA" water bill.)

___ ___ Do you use well water in your home? If yes, has it been analyzed for fluoride? (Circle one) Yes / No

___ ___ Does your child use a fluoride toothpaste?

___ ___ Do you give your child any other form of fluoride? What? ____

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Consent of Dental Treatment

I request and authorize Durham Pediatric Dentistry & Orthodontics to examine, clean and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the doctor examining my child to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic & academic purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The dentists will provide an environment to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

Signature ___________________________________ **Relationship to patient** __________________ **Date**___________

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Payment Policy

I will be responsible for any charges incurred on this child for dental treatment. I understand that by failing to make payments to Durham Pediatric Dentistry & Orthodontics my account can be turned over to a collection agency. Durham Pediatric Dentistry & Orthodontics will no longer provide dental care for my child 30 days after turn over. In cases of divorce, the custodial parent is responsible for any charges incurred.

Signature ___________________________________ **Relationship to patient** __________________ **Date**___________