PEDIATRIC DENTAL ACQUAINTANCE FORM

Date _____

Demographic Information

Patient's Name _____ Birth Date _____ Age _____

Name they would like to be called _____ Sex (Circle one) F M Patient's Mobile Ph. # (____)_____

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

Home Phone # (____)_____ Names & Ages of Siblings _____

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

Parent 1's Employer _____ Work Ph. # (____)_____ Mobile # (____)_____

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

Parent 2's Employer _____ Work Ph. # (____)_____ Mobile # (____)_____

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 Search ☐ Website ☐ Facebook ☐ Instagram ☐ Magazine Ad
☐ Physician or Dentist_____ ☐ Parent in our practice_____ ☐ 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?_____

Do you consider your child to be: ___ Advanced ___ Progressing Normally ___ Delayed ___ Other _____

_____

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

___ ADHD	___ Heart Disease	___ Diabetes	___ Respiratory Problems	___ Speech Problems
___ Learning Disabilities	___ Rheumatic Fever	___ Gland Problems	___ Asthma	___ Vision Problems
___ Autism Spectrum	___ Bleeding/Transfusion	___ Thyroid Disorder	___ Cystic Fibrosis	___ Hearing Problems
___ Behavioral Problems	___ High Blood Pressure	___ Growth Issues	___ Cleft Lip/Palate	___ Skin Problems
___ Psychiatric Problems	___ Hepatitis A, B or C	___ Epilepsy/Seizures	___ Eating Disorders	___ Eczema/Psoriasis
___ Depression	___ Anemia	___ Cerebral Palsy	___ Stomach Problems	___ Cold Sores
___ Anxiety	___ Heart Murmur	___ Muscular Disorder	___ Ulcer	___ Cancer
___ Headaches	___ Sickle Cell	___ Joint Problems	___ Canker Sores	___ Bladder/Kidney
___ Frequent Infections	___ AIDS	___ Liver Disease	___	___

Adolescents: ___ STD ___ Substance Abuse, Alcoholism, Drug Addiction ___ Pregnancy or Nursing ___ Tobacco Use

Does your child have any disease, condition, syndrome or issue not listed here? _____

_____

Dental History

YES NO

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

Date of Last Visit _____ Dentist's Phone # (____)_____

___ ___ Has your child experienced any unfavorable reaction from previous dental care? If yes, please explain below.

_____

___ ___ Does your child suck a: ☐ Thumb ☐ Finger(s) ☐ Pacifier ☐ Other _____

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

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

___ Cavities ___ Toothache ___ Sensitive Teeth ___ Color of Teeth ___ Trauma ___ Gum Infections

___ Crowded or Crooked Teeth ___ Eruption Problems ___ Pain with Chewing ___ Grinding Teeth ___ TMJ Pain

___Jaw or Joint Noise ___ Other _____

How cooperative do you feel your child will be for this appointment?

___ Well behaved ___ Anxious ___ Uncooperative ___Unsure Comments: _____

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**_____