

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 Other Patient's Phone # (____) _____

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? _____

YES NO

Health History

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

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? _____

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 _____

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 _____

Notice of Privacy Practices

I have been provided with Durham Pediatric Dentistry & Orthodontics' Notice of Privacy Practices that provides a complete description of their policy on the use and disclosure of protected health information.

Signature _____ Relationship to patient _____ Date _____