



PEDIATRIC
AND
ADOLESCENT
DENTISTRY

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GENERAL INFORMATION (We ask that you please notify us if this information changes)

Legal name of child _____ Nickname _____

Child's birth date _____ Sex: M F Child's Soc. Sec. # _____

Father's name _____ Mother's name _____

Mailing address _____ Mailing address _____

City/State/Zip _____ City/State/Zip _____

Home phone _____ Home phone _____

Cell phone _____ Cell phone _____

Email _____ Email _____

Employer _____ Employer _____

Work phone _____ Work phone _____

Father's SS# _____ DOB _____ Mother's SS# _____ DOB _____

Parent's marital status (Circle) single married widowed separated divorced

Does child live with both parents? (Circle) yes no

If not, with whom does child reside? _____

Relationship _____ Address _____

Home phone _____ Cell phone _____

Siblings seen in our office _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize Pediatric and Adolescent Dentistry, Ltd., to use and disclose my protected health information to carry out treatment, payment activities, and healthcare operations.

Signed _____ Date _____

DENTAL HISTORY

Is this your child's first visit to the dentist? _____ Has your child had a toothache recently? _____

Has your child experienced any unfavorable reactions from previous dental or medical care? _____ Explain _____

Which oral habits are currently present? ___ Mouth breathing ___ Thumb/finger sucking ___ Nail biting ___ Pacifier

At what age did your child stop nursing or taking a bottle? _____

How often are your child's teeth brushed per day? _____ By whom? _____

Is your child taking any vitamins or fluoride? _____ Is there a history of "night grinding" while sleeping? _____

Is there anything else about your child that you think we should know in order to better treat his or her dental needs? _____