



# WELCOME



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Since our practice is based on preventative care, we strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

### About your Child...

Name \_\_\_\_\_ Nickname \_\_\_\_\_ Male / Female

Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_ Adopted Y / N

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Special Interests, Sports, Hobbies \_\_\_\_\_

Who do we thank for referring you? \_\_\_\_\_

Are there any dental concerns that you are aware of at the present time? \_\_\_\_\_

Are there any special physical or mental needs we should be aware of? \_\_\_\_\_



### Dental/Medical History

Has your child been to the dentist before? Y / N

If yes, name of previous dentist? \_\_\_\_\_ Date of last visit? \_\_\_\_\_

Is your child allergic to any medications? Y / N

Any other medical allergies such as Latex or Red Dye? Y / N

If yes, please list \_\_\_\_\_

Please list all medications your child is currently taking \_\_\_\_\_

Have you been told your child needs antibiotics before dental appointments? Y / N

Child's Physician \_\_\_\_\_ Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_



### Medical Conditions and Habits

Does or has your child ever had any of the following medical conditions: (Please circle one)

Heart Murmur Y / N Any Heart problems Y / N Convulsions/Epilepsy Y / N

Cancer Y / N Diabetes Y / N Rheumatic Fever Y / N

Asthma Y / N HIV/AIDS Y / N Hemophilia Y / N

ADD/ADHD Y / N Hearing Impairment Y / N Any Bleeding Problems Y / N

Operations/Hospital Stays Y / N If yes, please explain \_\_\_\_\_

Does your child have any of the following habits:

Thumb / Finger Sucking Teeth Grinding Pacifier Nursing / Bottle Feeding



Please Complete Other Side

### HIPAA Acknowledgement

I have been notified of and acknowledge the Privacy Practices of Pediatric Dentistry of Sunset Hills.

\_\_\_\_\_ (Initials)

Father's Information

Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Home Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Cell Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Marital Status      M      S      W      D  
Employer \_\_\_\_\_  
Work # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext \_\_\_\_\_  
Occupation \_\_\_\_\_

Mother's Information

Name \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Home Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Cell Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Marital Status      M      S      W      D  
Employer \_\_\_\_\_  
Work # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Ext \_\_\_\_\_  
Occupation \_\_\_\_\_

Legal Guardian (if applicable)

Name \_\_\_\_\_  
Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_      Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Home Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Cell Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Address \_\_\_\_\_      City \_\_\_\_\_      State \_\_\_\_\_      Zip \_\_\_\_\_  
Employer \_\_\_\_\_      Work # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Ext \_\_\_\_\_  
Occupation \_\_\_\_\_



Dental Insurance Primary

Dental Insurance Co. \_\_\_\_\_  
Insurance Co. Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Group # \_\_\_\_\_

Dental Insurance Is Provided Through:

Insured's Name \_\_\_\_\_  
Relationship to Child \_\_\_\_\_  
Insured's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Insured's ID # \_\_\_\_\_  
Insured's Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Insured's Employer \_\_\_\_\_

Dental Insurance Secondary

Dental Insurance Co. \_\_\_\_\_  
Insurance Co. Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Group # \_\_\_\_\_

Dental Insurance Is Provided Through:

Insured's Name \_\_\_\_\_  
Relationship to Child \_\_\_\_\_  
Insured's Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Insured's ID # \_\_\_\_\_  
Insured's Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Insured's Employer \_\_\_\_\_



In the event of an emergency, who should we contact (other than parent)?

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
Cell Phone # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_      Alternate # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Please provide the e-mail address of the parent who will bring the child to the office most often.

1.) Name \_\_\_\_\_ E-mail \_\_\_\_\_

In the event that the above e-mail address fails, please provide a current alternate e-mail address.

2.) Name \_\_\_\_\_ E-mail \_\_\_\_\_

*PDSH WILL USE THE PROVIDED INFORMATION STRICTLY FOR PATIENT CORRESPONDENCE ONLY.  
THIS INFORMATION WILL NOT BE RELEASED TO ANY OTHER PARTIES OUTSIDE OF PDSH.*



*I understand the information I have given is correct. That it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the Pediatric Dentistry of Sunset Hills staff to perform the necessary services my child may need. I understand that the parent or guardian accompanying the child is responsible for payment of all deductibles and co-pays due at time of service. I agree to pay any additional charges related to the cost of collection (including, but not limited to, collection agency fees, reasonable attorney fees and court costs) in the event I would fail to pay my bill.*

Signature of Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_