WELCOME!

Thank you for choosing Fishers Pediatric Dentistry for your child's dental care!

PATIENT INFORMATION

Name: ______________________ **Nickname:** ______________ **DOB:** ______________ **Gender:** ❑ M ❑ F
Street Address: ______________________ **City:** ______________ **State:** __________ **Zip:** __________
Primary number for appointment confirmations: ( ) -
Who is accompanying the child today?
Name: ______________________ **Relation:** ❑ Biological ❑ Adopted ❑ Foster ❑ Nanny ❑ Other: ______________
Is your child a ward of the state? : ❑ Yes ❑ No **If yes, case worker's contact information:** ______________________

PARENT INFORMATION

Who does the patient live with? : ❑ Guardian 1 & 2 ❑ Guardian 1 ❑ Guardian 2 ❑ Other: ______________

GUARDIAN (I)

Name: ______________________ **Gender:** ❑ M ❑ F
DOB: ______________ **SS#:** ______________
Marital Status: ❑ Single ❑ Married ❑ Domestic Partnership
❑ Separated ❑ Divorced ❑ Widowed
Home: ( ) - **Cell:** ( ) -
Email: ______________________
❑ *Check box if Address is same as patient's listed above.*
Street Address: ______________________
City: ______________ **State:** __________ **Zip:** __________
Employer: ______________________
Work: ( ) -

GUARDIAN (II)

Name: ______________________ **Gender:** ❑ M ❑ F
DOB: ______________ **SS#:** ______________
Marital Status: ❑ Single ❑ Married ❑ Domestic Partnership
❑ Separated ❑ Divorced ❑ Widowed
Home: ( ) - **Cell:** ( ) -
Email: ______________________
❑ *Check box if Address is same as patient's listed above.*
Street Address: ______________________
City: ______________ **State:** __________ **Zip:** __________
Employer: ______________________
Work: ( ) -

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured: ______________________
DOB: ______________ **SS#:** ______________
Employer: ______________________
Phone: ( ) -
Insurance Co.: ______________________
Street Address: ______________________
City: ______________ **State:** __________ **Zip:** __________
Phone: ( ) -
Group/Policy #: ______________________
I.D. #: ______________________

SECONDARY COVERAGE

Name of Insured: ______________________
DOB: ______________ **SS#:** ______________
Employer: ______________________
Phone: ( ) -
Insurance Co.: ______________________
Street Address: ______________________
City: ______________ **State:** __________ **Zip:** __________
Phone: ( ) -
Group or Policy #: ______________________
I.D. #: ______________________

REFERRAL INFORMATION

❑ Sibling(s): ______________________
❑ Friend: ______________________
❑ Pediatrician/Physician: ______________________
❑ Dentist/Dental Office: ______________________
❑ Insurance: ______________________
❑ School/Daycare: ______________________
❑ Community Event: ______________________

❑ Google
❑ Website
❑ Facebook
❑ Angie's List
❑ Print Ad (magazine, newspaper, etc): ______________________
❑ Media Ad (radio, movie theater, etc.): ______________________
❑ Other: ______________________

DENTAL HISTORY

DENTAL CONCERNS

What is the primary reason for today's visit? : ❑ Cleaning ❑ Trauma/Dental Emergency ❑ Consult for Decay

Has your child ever been to the dentist? : ❑ Yes ❑ No

(If Yes) Previous/Present Dentist: ______________________________ **Date Last Exam:** ______________ **Date Last X-Rays:** ____________

Do you think your child will react well to treatment? : ❑ Yes ❑ No

Please describe any tips/tricks that will help our team provide a positive experience for your child's visit: ____________________________

____

DENTAL HABITS

Does your child currently… (check all that apply)

❑ Suck Thumb/Finger ❑ Suck/Bite Lips ❑ Bite/Chew Nails ❑ Tongue Thrust ❑ Bottle Feed

❑ Use Pacifier ❑ Tongue/Cheek Chew ❑ Clench/Grind Teeth ❑ Mouth Breather ❑ Breast Feed

HYGIENE ROUTINE

(check all that apply)

❑ Fluoride Toothpaste ❑ Consume Fluoridated Water ❑ Brushing by Child: ____/day ❑ Snack between Meals - Type of snacks:

❑ Fluoride Mouthwash ❑ Dental Floss: ____/week ❑ Brushing by Parent: ____/day ______________________________

MEDICAL HISTORY

Are immunizations current? : ❑ Yes ❑ No

Child's Physician: ____________________________________ **Phone: (___) _____ - __________** **Date Last Exam:** ______________________

History of Hospitalizations / Operations / Emergency Room Care / Recent Illnesses (explain)**:** ____

____

Current Medications: ____

Is your child followed by a specialist? : ❑ Yes ❑ No **If yes, provide name & contact information:** _______________________________

Has your child been diagnosed and/or treated for any of the following… (check all that apply)

❑ Blood Disorder/Anemia
❑ Abnormal Bleeding/Hemophilia
❑ Immune Disorder/HIV/AIDS
❑ Cancer/Tumor/Leukemia
❑ Heart Murmur/Defect/Surgery
❑ Epilepsy/Seizures/Convulsions
❑ Cerebral Palsy
❑ Cystic Fibrosis
❑ Kidney Problems
❑ Liver Disease/Jaundice/Hepatitis
❑ Diabetes
❑ Sickle Cell Trait
❑ Stomach/GI Disorders

❑ Tuberculosis (TB)
❑ Asthma/Reactive Airway
❑ Tonsillitis
❑ Congenital Birth Defects
❑ Premature/Low Birth Weight
❑ Cleft Lip/Palate
❑ Autism Spectrum
❑ ADD/ADHD
❑ Eating Disorder
❑ Speech Disorder
❑ Vision Problems
❑ Hearing Problems
❑ Deaf
❑ Mental/Cognitive/Social Delay

❑ Other Condition (specify): ____________________
____

ALLERGIES:
❑ Drug: ____
❑ Food: ____
❑ Seasonal
❑ Hives
❑ Latex
❑ Other (specify): ______________________________

I affirm that the above information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I understand that Fishers Pediatric Dentistry may use and disclose pertinent health information and dental records to coordinate and manage dental care and related services to one or more health care providers or other dental specialists. I authorize the release of all information necessary to secure benefits such as obtaining reimbursement for services, confirming coverage, bill or collection activities and utilization review. I understand that I am responsible for the full balance of the account regardless of my dental benefits and directly assign Fishers Pediatric Dentistry all insurance payments otherwise payable to me. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees. I affirm that my signature represents my agreement to all of the terms mentioned above.

Guardian Signature: ____ **Date:** ______________________

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