LITTLE CHOMPERS
PEDIATRIC DENTISTRY

WELCOME KIDS

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

office@littlechomperspd.com | littlechomperspd.com

TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____
Last First Middle

Child's Birthdate: ___/___/___ Child's Age: _____

Nickname: _____ ❑ Male ❑ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: ( ) _____

Social Security #: _____

Child's Home Address: _____
#Apt. / Condo

_____
City State Zip Code

GENERAL INFORMATION

Who is accompanying the child today? _____

Name: _____ Relation: _____

Do you have legal custody of the child? ❑ Yes ❑ No

Who may we thank for referring you? _____

Other siblings: _____

Relative or friend not living with you: _____

Name: _____ Phone #: ( ) _____

Address: _____
City State Zip Code

PARENT'S INFORMATION

Person responsible for Account: _____ Parent's Marital Status: ❑ Married ❑ Single ❑ Partnered ❑ Divorced ❑ Separated

❑ Father ❑ Step Father ❑ Guardian

Name: _____ Birthdate: ___/___/___

Address: (if different than Child's): Hm#: ( ) _____

_____

SS #: _____ DL#: _____

Wk #: ( ) _____ Ext: _____ Cell/other #: ( ) _____

E-mail: _____

Employer: _____

Employer's Address: _____

_____

_____
City State Zip Code

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

_____
City State Zip Code

Insurance Phone #: ( ) _____

Group # (Plan, Local or Policy #): _____

❑ Mother ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: ___/___/___

Address: (if different than Child's): Hm#: ( ) _____

_____

SS #: _____ DL#: _____

Wk #: ( ) _____ Ext: _____ Cell/other #: ( ) _____

E-mail: _____

Employer: _____

Employer's Address: _____

_____

_____
City State Zip Code

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____

_____
City State Zip Code

Insurance Phone #: ( ) _____

Group # (Plan, Local or Policy #): _____

RELEASE

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature of Parent or Guardian Date

DENTAL HISTORY

Previous/ Present Dentist: _____ Last visit date: _____

Dentist Phone # : ( )_____

Why did you bring the child to see the dentist today?_____

_____

_____

Has the child ever taken any diet pills such as Phen-Fen? ❑ Yes ❑ No

(Also known as Redux or Pondimin) If so, when? _____

Is the child currently in pain? ❑ Yes ❑ No

Does the child require antibiotics before dental treatment? ❑ Yes ❑ No

Has the child ever had a serious/difficult problem associated with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain/tenderness in in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

Does the child floss his/her teeth daily? ❑ Yes ❑ No

Child's Physician:_____

Phone #: ( )_____ Date of Last Visit: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list any drugs that the child is currently taking: _____

_____

_____

Please list all drugs that the child is allergic to:

_____

_____

Y N Allergic to Latex
Y N Allergic to Nickel
Y N Allergic to Dyes
Y N Allergic to Metals
Y N Allergic to Plastic

MEDICAL HISTORY

Has the child experienced any of the following medical problems or been diagnosed with any of the following:

Y N Abnormal Bleeding/ Hemophilia
Y N ADD/ADHD
Y N AIDS/HIV+
Y N Anemia
Y N Any Hospital Stays/ Operations?
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Autism Spectrum
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Handicaps/Disabilities
Y N Hearing impairment
Y N Heart Murmur: Any other heart disorders, concerns or issues
Y N Hepatitis
Y N High Blood Pressure
Y N Hives
Y N Immune Suppressive Therapy
Y N Kawaski Disease
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Rheumatic Fever
Y N Rheumatoid Arthritis
Y N Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Are the child's immunizations current? ❑ Yes ❑ No

Is there anything you would like to discuss with the Doctor in Private? ❑ Yes ❑ No

Please discuss any serious medical problems the child experiences/ed:

_____

_____

Does/did the child experience any of the following?

Y N Bottle for Feedings
Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding Teeth
Y N Dental Phobia
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Speech Problems
Y N Thumb/finger Sucking
Y N Tongue/Cheek Sucking
Y N Tongue Thrust
Y N Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control made by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_____ _____

Signature of Dentist Date

Dentist's Comments: _____

_____

MEDICAL HISTORY UPDATE

Has there been any change in your child's health status since their last visit? ❑Yes ❑No

If Yes, Please explain: _____

_____

Has there been any change in your child's health status since their last visit? ❑Yes ❑No

If Yes, Please explain: _____

_____

_____ _____

Parent /Guardian Signature Date

_____ _____

Dentist Signature Date

_____ _____

Parent /Guardian Signature Date

_____ _____

Dentist Signature Date