PLEASE COMPLETE BOTH SIDES BEFORE YOUR SCHEDULED APPOINTMENT

River Valley Pediatric Dentistry

Dentistry For Children and Young People

Tim Lawrence, D.D.S. • David Ciesla, D.D.S., M.S.
3421 Old Greenwood Road • Fort Smith AR 72903
1-800-262-0621 • (479) 783-4182 • Fax (479) 783-4379 • www.rvpd.org

Patient's Legal Name: _____ Preferred Name: _____ Age: _____

Social Security #: _____ Sex: _____ Race: _____

Date of Birth: _____ Place of Birth: _____

Patient's Address: _____ Home Phone: _____
Street

_____ Cell Phone: _____
City State Zip Code E-Mail: _____

Has your child seen a dentist before? _____

If yes, Date of last dental care: _____

What doctor did they see: _____

What treatment was administered: _____

_____

Was your child bottle-fed or breast-fed?_____

Age discontinued _____

PURPOSE OF THIS APPOINTMENT: _____

_____

Do we treat other children in your family: _____

If so, names and ages: _____

_____

Has your child ever had an unfavorable experience in a dental office: _____

	YES	NO
Is your child in good health	___	___
Does your child have regular medical check ups?	___	___
Is your child up to date with all immunizations?	___	___
Is your child in pain at this time	___	___
Has your child experienced an unfavorable reaction to any medicine? If so, What: _____	___	___

	YES	NO
Is your child presently taking any kind of medication? If so, what: _____	___	___
Is your child a finger or thumb sucker?	___	___
Has your child been hospitalized since birth? Date: _____ Reason: _____	___	___
Does your child use a pacifier?	___	___
Does your child have a shunt? If so, where does it terminate: _____ _____	___	___

HEALTH HISTORY

CHECK ANY OF THE FOLLOWING THAT MAY PERTAIN TO YOUR CHILD

___ Bleeding Disorders	___ Epilepsy	___ Lung Problems
___ Sickle Cell Anemia	___ Diabetes	___ Brain Injury
___ Mental Disorders	___ Hepatitis	___ Liver Problems
___ Emotional Disorders	___ Tuberculosis	___ Kidney Problems
___ Nervous Disorders	___ Allergies	___ Cerebral Palsy
___ Hearing Disorder	___ Developmental & Physical Delay	___ Speech Disorder
___ ARC (Aids Related Complex)	___ Autism	___ Vision Disorder
___ Asthma	___ Heart Condition	___ ADD/ADHD

___ Other: _____

Please feel free to offer any information that you think might be helpful to us in treating your child: _____

_____

Please list any special interests or hobbies in which your child is involved: _____

_____

(OVER)

PERSON RESPONSIBLE FOR ACCOUNT: _____

FATHER'S NAME:_____ Date of Birth: _____SS#: _____

His Address: _____ Home Phone: _____
Street City State Zip Code

Father's Employer: _____ Phone: _____
Name Address

Dental Insurance Carrier: _____Primary or Secondary
(circle one)

MOTHER'S NAME: _____ Date of Birth: _____SS#:_____

Her Address: _____ Home Phone: _____
Street City State Zip Code

Mother's Employer: _____ Phone: _____
Name Address

Dental Insurance Carrier: _____Primary or Secondary
(circle one)

Name & Address of Nearest Relative: _____ Phone: _____

Appointment Confirmation Phone Numbers: _____
First Choice Second Choice

Child's Physician: _____Family Dentist: _____

Whom May We Thank For Referring You To Our Office: _____
Name Address

What is your water source: Private Well ___ Public System ___ Name of System: _____

County in which you live: _____ Does the water have fluoride? _____

AT CERTAIN AGES VARIOUS PROCEDURES MAY BECOME NECESSARY AS PART OF YOUR CHILD'S DENTAL CARE: Radiographs (x-rays), Fluoride treatments, Sedation/Nitrous Oxide (Laughing Gas). IF YOU HAVE ANY CONCERNS ABOUT THESE PROCEDURES, WE WILL BE GLAD TO DISCUSS THEM WITH YOU. If we feel any of these will be necessary for your child, we will consult with you prior to completing the treatment.

Please state concerns: _____

I agree to diagnostic procedures and dental treatment as found necessary and desirable by Tim Lawrence, D.D.S. or David Ciesla, D.D.S., M.S. for the patient named above. I will accept responsibility for this account should the named party fail or insurance benefits be denied.

I hereby authorize payment directly to the above named dentist of the group insurance benefit otherwise payable to me. I understand that I am responsible for any charges not covered by this authorization.

We try very hard to maintain our schedule so that all our patients can be treated promptly. Needless to say, cancelling with short notice, showing up late, or simply not showing up is disruptive for our schedule and unfair for our other patients who value prompt treatment. We understand that there are certain circumstances that are unavoidable so please let us know if you are unable to attend your appointment within 24 hours of your appointment or with as much notice as possible. Multiple missed appointments with no notice or short notice will result in either scheduling siblings on different days or even dismissal from our practice.

Please initial that you have read and understand our appointment policy. _____

_____

SIGNATURE DATE

Health History Reviewed By: _____

ABC PRINTING & GRAPHICS 702054