RiverValley Pediatric Dentistry

DENTISTRY FOR CHILDREN AND YOUNG PEOPLE

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PLEASE COMPLETE BOTH SIDES BEFORE YOUR SCHEDULED APPOINTMENT

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: ____________________

PURPOSE OF THIS APPOINTMENT: ____

Is your child in pain at this time? ______________

Has your child seen a dentist before? ____________

If yes, Date of last dental care: ________________

What doctor did they see: ________________

What treatment was administered: ____________

____

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

Family Dentist: ______________________

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

Age discontinued ______________

Does your child use a pacifier? ______________

Is your child a finger or thumb sucker? ____________

Do we treat other children in your family: __________

If so, names and ages: ____________________

____

Whom may we thank for referring you to our office?

____

PERSON RESPONSIBLE FOR ACCOUNT: ____

GUARDIAN'S NAME: ______________________________ Date of Birth: ________ SS#: ________

Guardian's Address: ____ Home Phone: __________
Street City State Zip Code

Guardian's Employer: ____ Phone: ______________
Name Address

Dental Insurance Carrier: ____ Primary or Secondary
(circle one)

GUARDIAN'S NAME: ______________________________ Date of Birth: ________ SS#: ________

Guardian's Address: ____ Home Phone: __________
Street City State Zip Code

Guardian'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

	Yes	No		Yes	No
Is your child in good health?	____	____	Is your child up to date with all immunizations?	____	____
Does your child have regular check ups?	____	____	Has your child been hospitalized since birth?	____	____

Child's Physician ____________________________ Date_______ Reason____________________________

Please check any of the following that apply to your child below:

____ ADD/ADHD
____ Anemia
____ Asthma
____ Autism
____ Autoimmune Disorder
____ Blood Disorder/Disease
____ Cancer
____ Cerebral Palsy
____ Cleft Lip &/or Palate
____ Congenital Heart Defect
____ Cystic Fibrosis
____ Dev. and Phy. Delay
____ Diabetes
____ Downs Syndrome
____ Epilepsy/Seizures
____ Excessive/ Abnormal Bleeding
____ Glaucoma
____ Headaches/Migraines
____ Head Injury
____ Hearing Disorder
____ Heart Disease
____ Heart Murmur/MPV (NO SBE)
____ Heart Murmur/MPV (SBE REQ)
____ Heart Surgery
____ Hemophilia
____ Hepatitis
____ High/Low Blood Pressure
____ HIV/AIDS
____ Hydrocephalus
____ Jaundice
____ Kidney Disease
____ Liver Disease
____ Lung Disease
____ Lupus
____ Malignant Hypothermia
____ Nervous Disorder
____ Neurological Disorder
____ Pacemaker
____ Port Placement/Removal
____ Prader-Willie Syndrome
____ Pregnancy
____ Radiation/Chemo
____ Renal Dialysis
____ Respiratory Disease
____ Shunt
____ Sinus Problems
____ Snoring/Sleep Apnea
____ Speech Disorder
____ Spina Bifida
____ Stomach Problems
____ Stroke
____ Thyroid Condition
____ Tuberculosis
____ Tumors/Growths
____ Ulcers
____ Vision Disorder
____ Other - Please List
____
____
____

Allergies:

____ Anesthetic -Local
____ Aspirin
____ Codeine
____ Food
____ Latex
____ Penicillin/ Amoxicillin
____ Sulfa
____ Other - Please List
____

Has your child ever had an unfavorable experience to any medicine? ____ If so, What: ____________________
Please list any medications your child is currently taking (include prescription and OTC): __________________
____
____

AT CERTAIN AGES VARIOUS PROCEDURES MAY BECOME NECESSARY AS PART OF YOUR CHILD'S DENTAL CARE: Radiographs (x-rays), Fluoride treatments, Amalgam Fillings, Stainless Steel Crowns, 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., P.A. or Emily Fourmy, D.D.S., P.A. 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. _______

To the best of my knowledge, ALL of the information given on this form is accurate. I understand the that River Valley Pediatric Dentistry relies on this information for treating my child and giving incorrect health information can be dangerous to my child. I will not hold River Valley Pediatric Dentistry responsible for any actions they take or do not take because of errors or omissions that I have made in completing this form.

____

Parent or Guardian Signature **Date**

Health History Reviewed By: _______