Coastal Pediatric Dentistry
Dr. Terri Hubbard

PATIENT INFORMATION

Patient _____ Date _____

Name child would like to be called _____ Birthday _____ Age _____ Sex _____

Race: ◯ Caucasian ◯ African American ◯ Hispanic ◯ Asian/Oriental ◯ American Indian ◯ Other

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

School _____ Grade _____

Names and ages of other children in the family _____

Mother _____ Mother's Employer _____

Social Security # _____ Cell Phone _____

Father _____ Father's Employer _____

Social Security # _____ Cell Phone _____

Who has legal custody of patient? _____

Person responsible for payment of account? _____ Date of Birth _____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit? _____

INSURANCE INFORMATION

Insurance Company: _____ Employer: _____

Name of Insured: _____ Relationship to Insured: □ Self □ Spouse □ Child □ Other

Insured Social Security Number: _____ Insured Date of Birth: _____

Insured Policy Number: _____ Insured Group Number: _____

HEALTH HISTORY

□ Yes □ No Is your child in good health? Name of child's physician _____

Date of last physical exam _____

□ Yes □ No Has your child ever had a health problem? _____

□ Yes □ No Are your child's immunizations up-to date? _____

□ Yes □ No Has your child had any operations? _____

□ Yes □ No Is your child currently taking any medications? _____

□ Yes □ No Were there any problems at birth? _____

□ Yes □ No Is your child allergic to anything? _____

CONTINUE ➡

Please check if your child has been diagnosed and/or treated for any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ Hepatitis	☐ Tuberculosis	☐ Mental Delays
☐ Anemia	☐ Epilepsy / Seizures	☐ Kidney Disease	☐ Congenital Birth Defects	☐ Physical Delays
☐ Asthma	☐ Excessive Bleeding	☐ Liver Disease	☐ Cerebral Palsy	☐ Social Delays
☐ Blood Disorder	☐ Frequent Headaches	☐ Rheumatic Fever	☐ Cleft Lip/Palate	☐ Speech Problem
☐ Cancer/Tumors	☐ Heart Murmur	☐ Stomach/ GI Disease	☐ Frequent Infections	☐ Heart Condition
☐ Sickle Cell	☐ Latex Allergy	☐ Sleep Apnea	☐ Penicillin Allergy	☐ Other

Please elaborate on any items checked _____

_____

Do you consider your child to be:
- ☐ Advanced in the learning process
- ☐ Progressing normally
- ☐ Slow in the learning process

DENTAL HISTORY

☐ Yes ☐ No Has your child ever been to the dentist? Date of Last Dental Visit? _____

☐ Yes ☐ No Has your child ever had dental x-rays? Date: _____

☐ Yes ☐ No Do you think your child will react well to dental treatment? Explain: _____

☐ Yes ☐ No Does your child suck a finger, thumb, or pacifier? Ages when? _____

☐ Yes ☐ No Does your child use dental floss? How often? _____

☐ Yes ☐ No Does your child have snacks between meals? _____

☐ Yes ☐ No Have your child's teeth been injured? When? Which teeth? _____

Treatment? _____

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds? _____

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Toothache	☐ Sensitive Teeth	☐ Surgical Mouth Treatment
☐ Gum Infections	☐ Color of Teeth	☐ Orthodontics	☐ Jaw Sounds
☐ Other			

Comments:

_____

_____

FLUORIDE HISTORY

☐ Yes ☐ No Is your home water supply fluoridated?

☐ Yes ☐ No Does your child use fluoride toothpaste?

☐ Yes ☐ No Does your child use fluoride supplements? Dose: ☐ 0.25mg ☐ 0.50mg ☐ 1.0mg

☐ Yes ☐ No Do you give your child any other forms of fluoride?

What? _____ Amount _____

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Hubbard and her staff to examine, clean, and provide my child with comprehensive dental treatment including fillings, crowns, extractions, and nitrous oxide, if required. I further request and authorize the taking of dental x-rays deemed necessary by the treating dentist to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment by using praise, explanation, and demonstration of procedures and instruments, and using variable voice tone. I understand that I will be responsible for any charges incurred on this child for dental treatment.

Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____