Pediatric Dentistry of Chattanooga

150 Stuart Crossing • Cleveland, TN 37312 • 423-476-2160
5572 Little Debbie Pkwy, Ste 110 • Ooltewah, TN 37363 • 423-238-4090
50 Bragg Lane • Ringgold, GA 30736 • 706-406-2196

1 Tell Us About Your Child

Today's Date: _____

Child's Name _____
Last First MI

❑ Male ❑ Female

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: (____) _____ SS#: _____

Email Address _____

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

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

Whom may we thank for referring you? _____

Has this child been to Pediatric Dentistry previously? ❑ Yes ❑ No

Other family members seen by us? _____

Previous/Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed

3 Mother's Information:

❑ Biological Mother ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: _____

Home #: _____ Cell #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Work #: _____

SS#: _____

Driver's License No. _____ Exp. _____

4 Father's Information:

❑ Biological Father ❑ Step Father ❑ Guardian

Name: _____ Birthdate: _____

Home #: _____ Cell #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Work #: _____

SS#: _____

Driver's License No. _____ Exp. _____

5 Person(s) with Consent to Bring My Child to Appointments:

Name: _____ Relation: _____

Name: _____ Relation: _____

Emergency Contact

Name: _____ Relation: _____

Address: _____

Phone #: _____

6 Primary Dental Insurance

Insurance Co.Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ SS#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? ❑ Yes ❑ No

7 Why did you bring the child to the dentist today?

_____

Has the child ever had any unhappy dental visits? ❑ Yes ❑ No

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

Is the child taking fluoridated supplements? ❑ Yes ❑ No

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

Child's Physician: _____

Phone #: _____

Date of last visit to physician: _____

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

Please describe the child's current health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

Are your child's immunizations up to date? ❑ Yes ❑ No

_____

Does your child have any drug allergies? ❑ Yes ❑ No

If yes, please list _____

Is your child allergic to latex? (Balloons, Bandaids, Bananas) ❑ Yes ❑ No

Please list any previous hospitalizations/surgeries/serious illnesses:

_____

8 Does the child have any of the following habits?

Lip Sucking / Biting ❑ Yes ❑ No

Nail Biting ❑ Yes ❑ No

Grinds Teeth ❑ Yes ❑ No

Thumb / Finger Sucking ❑ Yes ❑ No

9 Has the child ever had any of the following medical problems?

- ❑ Abnormal Bleeding/Hemophilia
- ❑ Allergies
- ❑ Anemia
- ❑ Anaphalaxis
- ❑ Any Hosptial Stays/Operations
- ❑ Artificial Heart Valve/Joint
- ❑ Arthritis
- ❑ Asthma
- ❑ Autism
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Chemotherapy/Radiation
- ❑ Chicken pox
- ❑ Cleft lip/Palate
- ❑ Convulsions/Epilepsy/Seizures
- ❑ Cystic Fibrosis
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Down Syndrome
- ❑ Emotion, Mental, Nervous Disorder
- ❑ Frequent Nose Bleeds
- ❑ Handicaps/Disabilities
- ❑ Hearing Impairment
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis
- ❑ Herpes/Cold Sores
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Intellectual Disability
- ❑ Kidney/Liver Problems
- ❑ Leukemia
- ❑ Measles
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Pregnancy
- ❑ Premature Birth
- ❑ Renal Dialysis
- ❑ Rheumatic/Scarlet Fever
- ❑ Sickle Cell Disease
- ❑ Speech Difficulties
- ❑ Thyroid Disease
- ❑ Tuberculosis (TB)
- ❑ Vision Problems
- ❑ Any Syndromes

If any of the above are checked, please give a brief explanation:

_____

_____

_____

10 Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian

The parent or guardian who accompanies the child is responsible for payment of time of service unless prior arrangements have been approved.