South Tampa Pediatric Dentistry

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PATIENT INFORMATION

Patient: _____ Today's Date: _____

Nickname/Preferred Name: _____ Date of Birth: _____ Age: _____ Sex: M F

School: _____ Grade: _____

Home Address: _____ City: _____ Zip: _____

Phone Number: _____ Social Security Number: _____

Dr. Lesley should thank _____ for referring us to South Tampa Pediatric Dentistry.

Reason for today's visit: _____

MOTHER'S INFORMATION:

Name: _____ Date of Birth: _____

Employer: _____ Social Security Number: _____

Work Phone #: _____ Home Phone #: _____ Cell Phone #: _____

FATHER'S INFORMATION:

Name: _____ Date of Birth: _____

Employer: _____ Social Security Number: _____

Work Phone #: _____ Home Phone #: _____ Cell Phone #: _____

Parents' Marital Status (M)_____ (S) _____ (D)_____

Who has legal custody of this patient? _____

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

Name: _____ Relationship to Patient:_____

Billing Address: _____ City: _____ Zip: _____

Work Phone #: _____ Home Phone #: _____ Cell Phone #: _____

E-mail address: _____

HEALTH INFORMATION

Physician's Name: _____ Phone #: _____

Date of last physical: _____

Y N Are all of your child's immunizations up to date?

Y N Has your child ever been hospitalized? If yes, please describe when and why: _____

Y N Has your child ever been treated in the emergency room? If yes, please describe when and why:

_____

Y N Has your child ever had surgery? If yes, please describe when and why: _____

Y N Does your child need pre-medication with antibiotics before dental appointments?

Patient Name: _____

Please list all current medications this patient is taking, including the reason for taking the medication:

_____

_____

Please list any known allergies: _____

Has your child ever been diagnosed with or treated for the following?

Y N	ADHD/hyperactivity	Y N	breathing problems	Y N	heart murmur	Y N	premature birth
Y N	allergies	Y N	cancer/tumor	Y N	hepatitis	Y N	rheumatic fever
Y N	anaphylactic reaction	Y N	cerebral palsy	Y N	high blood pressure	Y N	seizures/epilepsy
Y N	anemia	Y N	cleft lip/palate	Y N	HIV/AIDS	Y N	sleep apnea
Y N	arthritis	Y N	delayed speech	Y N	kidney disease	Y N	sickle cell disease
Y N	artificial joints	Y N	developmental delay	Y N	latex sensitivity	Y N	sinus problems
Y N	asthma	Y N	diabetes	Y N	liver disease	Y N	STD
Y N	birth defects	Y N	fainting spells	Y N	low birth weight	Y N	tonsillectomy
Y N	bladder disease	Y N	head/neck injury	Y N	mental/nervous disorder	Y N	tuberculosis
Y N	bleeding problems	Y N	hearing impairment	Y N	pacemaker	Y N	vision problems
Y N	blood disorder	Y N	heart condition	Y N	pregnancy	Y N	other

If other, please specify: _____

Please elaborate on any of the above marked yes: _____

_____

DENTAL INFORMATION

When was your child's last dental visit? _____

Previous dentist's name and address: _____

Why did your child leave his/her previous dentist? _____

When were X-rays last taken of your child's teeth? _____

Y N	Do you have any concerns regarding his/her teeth?	Y N	Does your child use dental floss?
Y N	Do you supervise or assist your child in brushing his/her teeth?	Y N	Does your child use fluoride tablets or rinses?
Y N	Does your child have any tooth, jaw, or muscle discomfort?	Y N	Does your child use toothpaste with fluoride?
Y N	Does your child only drink bottled, highly-filtered, or well water?	Y N	Does your child get cold sores or canker sores?
Y N	Does your child have a click, pop, or other noise in the jaw joint?	Y N	Does your child clench or grind his/her teeth?
Y N	Does your child frequently eat sweets and/or drink juices or sodas?	Y N	Does your child have frequent headaches?
Y N	Are any of your child's teeth uncomfortable for him/her when he/she bites?	Y N	Are your child's teeth sensitive to hot or cold?
Y N	Do your child's gums bleed when brushing or flossing?		
Y N	Does your child have any concerns about the appearance of his/her teeth?		
Y N	Does your child have a history of an accident or injury involving the teeth/jaws?		
Y N	Does your child have a habit of snoring or mouth breathing?		
Y N	Does your child have a current or previous habit involving a pacifier or thumb/finger sucking?		
Y N	Does your child have a history of going to sleep with a baby bottle or on demand breast feeding?		

How has your child reacted to previous medical or dental procedures? _____

How do you expect your child to react in the dental chair? _____

What are your child's interests and hobbies? _____

Please list any conditions or concerns regarding your child's health that have not been covered in this questionnaire: _____

I, the undersigned parent/legal guardian of this child, certify that the above is accurate and complete to the best of my knowledge. I will notify the doctor(s) and/or the staff of ***any*** change in the above prior to ***any*** appointment.

Signature: _____ Name: _____

Date: _____ Relationship to Patient: _____

OFFICE POLICIES

We reserve your appointment time specifically for you. Please arrive early for all appointments. If you need to reschedule, please give at least 48 business hours notice so we may give someone else the opportunity to use that time. A fee may be charged for late arrivals, late cancellations, and missed appointments.

All children must be accompanied to all appointments by an adult aged 18 or older. This adult must remain on the premises during the entire appointment.

Cell phone, tablet, and other electronic device usage is prohibited during appointments. The use of cameras, audio, and video recording devices is prohibited without express written consent.

CONSENT FOR DENTAL TREATMENT

I, the undersigned parent/legal guardian, hereby give consent for the doctor(s) and/or clinical staff to examine this child, clean his/her teeth, perform all necessary dental treatment, administer local anesthetics, administer medications, apply topical fluoride, take diagnostic radiographs (X-rays), take clinical photographs, obtain study models and other records necessary for an accurate diagnosis for my child. I understand that dental treatment for children involves behavior guidance, which may include the use of praise, explanation and demonstration of procedures and instruments, variable voice tone, mouth props, nitrous oxide (laughing gas), or protective stabilization when necessary to promote cooperative behavior and a positive experience and to protect my child from potential injury.

FINANCIAL POLICIES

Payment is expected at the time of service. For your convenience, we gladly accept cash, checks, Visa, MasterCard, American Express, Discover, PayPal cards, and Care Credit. We will also file your insurance paperwork for you so that you may be reimbursed for services rendered. Please note that your insurance reimbursement rates may differ from the fees at South Tampa Pediatric Dentistry. In cases where the fees of South Tampa Pediatric Dentistry exceed those of your insurance reimbursement, you will be responsible for paying the difference. I agree that I am responsible for all charges for this child's dental treatment. I authorize South Tampa Pediatric Dentistry to file my dental insurance reimbursement paperwork and to call me regarding this account.

HIPAA NOTICE OF PRIVACY PRACTICES

I have legal authority for the patient and acknowledge that I have received and reviewed by copy of South Tampa Pediatric Dentistry's HIPAA Notice of Private Practices.

Signature: _____ Name: _____

Date: _____ Relationship to Patient: _____

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