Frederick Pediatric Dental Associates

Please complete both sides of this form so we may give your child the best care.

Today's Date:______________

Patient Information:
Name:____ Male or Female
Age: ____________________ Birthdate:______________
Home Address:_________________________________ Home Phone #:________________
____

Who is Accompanying your child today?_______________________ relation:_____________
Do you have legal custody of this child? yes or no

Mother's Information:
Single Married Divorced Widowed Remarried Partnered
Name:____
Birthdate:______________________ SSN:_________________________
Home address: (if different than above)_________________________________
____
Home phone:___________________ Work: ___________________ Cell:________________
Employer:____

Father's Information:
Single Married Divorced Widowed Remarried Partnered
Name:____
Birthdate:______________________ SSN:___________________________
Home Address: (if different than above) ______________________________
____
Homephone:________________ Work:__________________ Cell:____________________
Employer:____

Primary Dental Insurance:
Insurance Company:________________________ Address:____________________________
Policy Holder:______________________________ DOB: ____________________________
ID# _________________________ Group# _____________ Employer___________________

Responsible Party:
Who is financially responsible for account (if someone other than parents listed above)?
____

I have been provided a copy of the Notice of Privacy Practices and understand the notice. The notice will apply to all patients within the same family. I certify the above information to be correct. I authorize Frederick Pediatric Dental Associates to perform any necessary dental care for my child. I understand it is my responsibility to inform the office of any changes with involving the information above.

_____________________________ _________________________
Parent/Guardian/Responsible Party Print Name

Patient's Name _____________________ Nickname_______________ D.O.B._________

Medical History:

Child's Physician:______________________________ Phone#________________________
Date of last physical Examination:_________________ Results:________________________
Child's Weight: ______________________ Child's Height:________________________
Is your child under the care of a physician now?___________
Why?____
Is your child taking any medications?

Drug	Dose	Frequency	Reason

Why did you bring the child to the dentist today?____________________________________
Is there pain or discomfort?____
Is this your child's first visit?______ Previous Dentist________________ last visit_________
Has your child experienced problems with previous dental care? _______________________
If yes, please explain.____
Has your child's teeth ever been injured? ________ How? ____________________________

Please check any medical condition that the child has or has had:

Allergies - drugs or foods Please list:____

Allergies Seasonal	Heart Murmur (antibiotics required?) __________
Accidents or severe infections	Cerebral Palsy
AIDS or HIV	Convulsions, seizures, or epilepsy
Anemia or Blood Disorders	Diabetes
Asthma or Lung Problems	Headaches
Autism	Vision Problems
Hyperactivity / ADHD/ ADD	Hospital stay or Operations
Liver Disease/ Hepatitis	Blood Transfusions
Malignancies (Cancer)	Developmental Disabilities
Speech or Hearing Impairments	Bleeding Problems
Kidney or Bladder Problems	Skin Problems
Tuberculosis	Other:____________________________________

Please describe any current medical treatment, pending surgery, recent injuries or any other information the dentist should be aware of or that has not been covered above.

____
____
Do you have any special concerns to discuss with the doctor in private? __________________

The signature of a parent or guardian signifies that all of the above information is true and correct.
Signature:__________________________ Relationship:________________ Date:__________
Doctor Signature:____ Date:__________
Doctor Notes:____
____