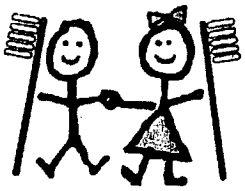
Pediatric Dentistry of Owensboro



Medical and Dental History

Child's Name: _____ Prefers to be called: _____
Child's Physician: _____ Physician's Phone: _____

- Is your child in good health? Yes or No
- Date of Last Medical Exam ___/___
- Is your child under the care of a physician? Yes or No Explain: _____
- Has your child had surgery/hospitalizations? Yes or No Explain: _____
- Is your child taking any medications? Yes or No Explain: _____
- Is your child allergic to medications, foods, etc.? Yes or No Explain: _____
- Are your child's immunizations up to date? Yes or No
- Do you have fluoride in your water? Yes or No Source of drinking water: city/well
- Were there any complications at birth? Yes or No Explain: _____
- Is this your child's first dental visit? Yes or No
- Whom may we thank for referring you to our office? _____
- What is the reason for your child's dental visit? _____
- Has your child had any unfavorable dental experiences? Explain: _____
- How often does your child brush? _____ Floss? _____ Do you help your child brush? ___
- Has your child ever had any injury to the face/teeth? Yes or No Explain: _____
- Any mouth habits? (finger, thumb, pacifier, mouth breather, sleeps with bottle/sippy cup)? _____
- Does your child use a "sippy" cup? Yes or No
- Does your child eat frequent snacks between meals? Yes or No
- Does your child drink juice/soda between meals? Yes or No If yes, how many per day? ____
- Do you expect your child to cooperate today? Yes or No
- Is there any information you feel might help us to better treat your child? _____

_____

Does your child have or have they ever had any of the following: (Please check all that apply)

☐ Asthma
☐ Autism
☐ AIDS/HIV
☐ Anemia
☐ Birth Defects
☐ Brain Injury
☐ Blood Transfusion
☐ Behavioral/Learning Disability
☐ Cancer
☐ Cerebral Palsy
☐ Cleft Lip/Palate
☐ Developmental Delay
☐ Diabetes
☐ Emotional/Mental Disorder
☐ Epilepsy/Seizures
☐ Endocrine Disorder
☐ Fainting
☐ Frequent Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Latex Allergy
☐ Liver Disease
☐ Lung Problems
☐ Mitral Valve Prolapse
☐ Premature Birth
☐ Radiation Treatment
☐ Rheumatic Fever
☐ Sleep Apnea
☐ Speech Disorder
☐ Skin Rash
☐ Spina Bifida
☐ Stroke
☐ Syndrome
☐ Thyroid Problem
☐ Tobacco/Alcohol Habit
☐ Visual Problems
☐ Other _____

- If you answered yes to any of the above, please explain: _____

Treatment Authorization/Financial Agreement

Child's Name: _____ Child's SSN: ___/___/____ Sex: M/F (Circle)
Age: ___ DOB: ___/___/___ School: _____
Do we see other children in your family? Yes or No Names: _____
Father's Name: _____ DOB: ___/___/___ SSN: ___/___/____
Address: _____ Phone: _____
_____ Zip Code: _____ Cell Phone: _____
Employer: _____ Phone: _____
Mother's Name: _____ DOB: ___/___/___ SSN: ___/___/____
Address: _____ Phone: _____
_____ Zip Code: _____ Cell Phone: _____
Employer: _____ Phone: _____
Child Resides with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other _____
Name of Dental Insurance Carrier: _____ SSN of insured: ___/___/____
Is Insurance Carried Through Employer? Yes or No Group # _____
Name of Health Insurance Carrier: _____ SSN of insured: ___/___/____
Is Insurance Carried Through Employer? Yes or No Group # _____
Phone Number for Confirmation of Appointments: _____
Person to be Contacted in Case of Emergency (other than parents):
Name: _____ Relation: _____ Phone: _____

Please Note:

Appointment and Cancellation Policy: One parent is permitted to remain with each child during treatment (excluding sedation appointments). Dr. Crews will discuss with you the terms and conditions for this privilege. Other guests/siblings must remain in the waiting area accompanied by an adult.
We request that 24-hour notice be given if you cannot bring your child for their scheduled appointment. You will be changed a $25.00 fee for broken appointments when illness is not a factor and 24-hour notice is not given.
I have read and fully understand the above **Appointment and Cancellation Policy** and accept all provisions.

Signature of Parent or Legal Guardian: _____ Date: _____

Consent for Dental Treatment

I request and authorize Dr. Jay Crews to examine, clean, and provide dental treatment on my child's teeth including but not limited to the use of local anesthetic and/or nitrous oxide ("laughing gas"). I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Crews to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or education purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Crews will provide an environment likely to help children to learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature of Parent or Legal Guardian: _____ Date: _____
Witness: _____

Comments: