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(Fellow of the Academy of General Dentistry)

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Creekview Family Dentistry

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Date: _____

Patient's First Name _____ Middle Initial _____ Last Name _____ Nickname: _____

Why did the child come to the dentist today? _____

Home Address _____

City _____ Zip _____ Patient's Home telephone # _____

Date of Birth ____/____/____ Sex: M () F () Grade: _____ School _____

Social Security Number: ____-____-____ E mail Address of parent (if any) _____

Do you have any other children? Yes () or No () Names and Ages of your children (include this child)

1) _____ 2) _____ 3) _____ 4) _____ 5) _____

Who is accompanying this child today? _____ Relationship: _____

With whom does the child primarily reside? () Both parents () Mother () Father () Guardian () Other

Father's Information () father () stepfather () guardian

Name: _____ Date of Birth ____/____/____ S S N ____/____/____

Address _____ City _____ Zip _____ Hm Telephone # _____

Occupation _____ Employer _____ Wk Phone# _____ Cellular _____

Mother's Information () mother () stepmother () guardian

Name: _____ Date of Birth ____/____/____ S S N ____/____/____

Address _____ City _____ Zip _____ Hm Telephone # _____

Occupation: _____ Employer _____ Wk Phone: _____ Cellular _____

Whom may we thank for referring you ? Walk-in () Sign/Location () Internet () Google ()

AT&T Yellow Pages () Verizon Yellow Pages () Your Town Yellow Pages () Other Yellow Pages ()

Val Pak Mail () Money Mailer () Letter () Newsletter () Flyer with our Staff Picture ()

Friend/ Family/ Employee (Name: _____) Other _____

Dr. Mathew does not participate in any of the managed care dental plans . Insurance is accepted and submitted on your behalf, but you are responsible for any charges your insurance does not cover at the time of service.

INSURANCE INFORMATION

Primary Insured Party's Full Name _____ Social Security Number ____/____/____

Relationship to Patient: Parent () Step Parent () Other (specify : _____)

Employer _____ Insurance Company Name _____

Ins. Address _____ Ins Phone # _____

Group Number _____ Subscriber ID _____

MEDICAL HISTORY

Physician's Name _____ Address _____ Phone: _____

1. Has your child been a patient in a hospital during the last year? Yes () No ()
2. Has your child been under the care of a Physician within the last year?
Yes () No () Explain _____
3. Has your child ever had any excessive bleeding requiring special treatment? Yes () No ()
4. Does your child smoke ? Yes () No ()
5. Does your child use snuff or smokeless tobacco? Yes () No ()

Pediatrician's Name _____ City _____ Phone: _____
Former Dentist's Name _____ City _____ Phone: _____

Why are you changing dentists? _____

Is this your child's first dental visit? Y () N () When was the last time your child had a check up and professional cleaning? _____ x-rays? _____ Does your child drink City water () Well water (unfluoridated) ()
Has your child had sealants placed on his/her permanent molars to prevent decay? Y () N () When? _____
Has your child been to an orthodontist for an evaluation of his/ her bite? Y () N ()
Is your child currently seeing an orthodontist? _____ If so, who? _____, what city? _____
Is your child having pain today? Y () N () Please describe: _____
Is your child apprehensive about dental treatment Y () N () If so, what is he / she apprehensive about ? _____

Have you been told to give your child an antibiotic before dental treatment? Y () N ()

For what condition does your child need to be premedicated with an antibiotic? _____

Does your child brush his/ her own teeth? Y () N (), If not Do you brush your child's Teeth Y () N ()

Has your child ever had any serious problems with previous dental work Y () N ()

Describe: _____

Check any of the following which your child ever had or have at present.

- | | | |
|--|---|---|
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> Epilepsy or seizures | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting or Dizzy Spells | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Angina Pectoris (chest pain) | <input type="checkbox"/> Fever blisters | <input type="checkbox"/> Pain in Jaw Joints |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Artificial bone /valve /joint | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Growth Disorder | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood transfusion | <input type="checkbox"/> Handicaps/ Disabilities | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Pace Maker | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Cancer (what kind?) _____ | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Disease / Attack | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cold Sores or Fever Blisters | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Congenital Defect | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Tourette Syndrome |
| <input type="checkbox"/> Congenital Heart Defect / Lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Cortisone (steroid) medicine | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV + / AIDS / ARC | <input type="checkbox"/> Venereal Disease (Syphilis, Gonorrhea) |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> Drug/Alcohol abuse | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Any operations? (What?) _____ |

If your child allergic to any of the following, please check.

Codeine Dental Anesthetics Penicillin Erythromycin Clindamycin Latex

Please list any other drugs that your child is allergic to: _____

Please list all medications/herbs/over the counter drugs your child is taking and why he/she is are taking them.

1) _____ for _____ 2) _____ for _____

Please list any other medical condition or problem that your child has been or is being treated for: _____

Does your child suck his/ her thumb (or fingers) or pacifier? Y () N ()

Could your child be pregnant or be taking birth control pills? Y () N () Possibly ()

Parent or Guardian must be present in the reception room while treating a patient under 18

It is recommended that adults do not stay in the treatment room, while the child is being treated unless the child is under 5

I affirm that the information given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical history. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant as she deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and / or her staff. I authorize this office to use this signature on all insurance claims. I agree to pay for all services rendered by this office regardless of insurance benefit.

Signature of parent/guardian _____

Date _____