Castle Rock Smiles
Pediatric Dentistry

Date: _____

PATIENT INFORMATION

Child's Name: _____ Nickname: _____ Gender: ☐ Male ☐ Female
Address: _____ City: _____ State: ____ Zip: _____
Home Phone: _____ Age: _____ DOB: ___/___/_____
School Attending: _____ Grade Level: _____

RESPONSIBLE PARTY INFORMATION

Parent/Legal Guardian: _____ Relation to Patient: _____
Employer: _____ Work#: _____ Mobile#: _____ DOB: ___/___/_____
Spouse's Name: _____ Relation to Patient: _____
Employer: _____ Work#: _____ Mobile#: _____ DOB: ___/___/_____
Guardian's Email: _____
Who has legal custody? _____ Dental Insurance: Yes No
Person Responsible for Payment of Account: _____ SSN: _____
Names and ages of other children in the family:_____
Emergency Contact (other than parents): _____ Phone: _____

WHOM MAY WE THANK FOR REFERRING YOU?

☐ Our Website ☐ Brochure/Mailing ☐ Web Search ☐ Friend/Relative: _____
☐ Dentist/Physician: _____ ☐ Other: _____

INSURANCE INFORMATION--PRIMARY

Policy Owner's Name: _____ Policy Owner's SSN: _____ DOB: ___/___/___
Insurance Name: _____ Member ID: _____ Employer: _____
Group Name: _____ Group #: _____
Insurance Address: _____ Insurance Phone: _____

INSURANCE INFORMATION—SECONDAY (if applicable)

Policy Owner's Name: _____ Policy Owner's SSN: _____ DOB: ___/___/___
Insurance Name: _____ Member ID: _____ Employer: _____
Group Name: _____ Group #: _____
Insurance Address: _____ Insurance Phone: _____

DENTAL HISTORY

What is the reason for your child's dental visit? _____

Y N Is this your child's first dental visit?
Name of previous dentist: _____ Phone: _____
Date of last exam: _____ X-rays: _____

Y N Has your child had any previous unpleasant experiences with dental care?
Explain: _____

Y N Does your child suck a finger, thumb, or pacifier? _____

Y N Does your child use a bottle or sippy cup? _____

Y N Does your child snack frequently? What foods? _____

Y N Has your child had local anesthetic? Were there any problems? _____

Y N Has your child been sedated for dental treatment? Were there any problems? _____

Y N Has your child ever received injury to the face, mouth, or teeth? Explain _____
_____

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CHILD'S PRIMARY CARE PHYSICIAN/PEDIATRICIAN

Physician Name: _____ Practice Name: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone #: _____ Date of Last Physical Exam: _____ Immunizations Up To Date? _____

MEDICAL HISTORY

Has your child ever had or been diagnosed with any of the following medical problems?

Y	N	Abnormal Bleeding	Y	N	Congenital Heart Disease
Y	N	ADHD/ADD/ODD	Y	N	Convulsions/Epilepsy
Y	N	Allergies to any Drugs	Y	N	Diabetes
Y	N	Allergies to Medical Materials (ex. Latex)	Y	N	Hearing Impairment
Y	N	Any Hospitalizations	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia/Bleeding Disorder
Y	N	Asthma	Y	N	Hepatitis
Y	N	Autism	Y	N	HIV/AIDS
Y	N	Blood Transfusion	Y	N	Intellectual Disability
Y	N	Cancer/Tumors	Y	N	Kidney/Liver Problems
Y	N	Cerebral Palsy	Y	N	Premature Birth

If YES please explain: _____
_____
_____

Any other medical conditions not listed above? _____
List any medications your child is taking: _____
List any medications your child is allergic to: _____
List any other allergies: _____

CONSENT

The permission of a parent or guardian is necessary for dental treatment of a minor. I give Castle Rock Smiles Pediatric Dentistry, the doctor, assistant, and/or other staff colleagues, permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays), and other diagnostic aids. I have given a complete, true, and accurate report of my child's physical and mental health history. I have also reported any prior allergic reactions to drugs, food, insect bites, anesthetics, pollens, or dust, any blood or body diseases, gum or skin reactions, abnormal bleeding, and any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Signature: _____ **Date:** _____ **Relationship to Patient:** _____

Doctor Signature: _____ **Date:** _____