Sandhills Pediatric and Family Dentistry

Dr. Sidney Brooks and Dr. Bryan Dunston, DDS, PLLC

Pediatric Demographic Information

Date _____

Patient_____
Nickname_____
Date of Birth_____ Age_____ Sex: M_____ F_____
Child's SSC# _____
Home Address_____
street city state zip
Home Phone_____
Cell Phone_____ Email_____

Names and ages of other children in family_____

Child's Physician _____
Physician Address_____
street city state zip
Physician Phone_____

Child's School Name _____
Grade_____ Teacher _____
Parent/Guardian _____ Relationship to Patient_____
Mother _____ SS#_____
Mother's Employer _____ Phone _____
Father _____ SS#_____
Father's Employer _____ Phone _____

Who has legal custody of patient? _____
Dental Insurance Provider: _____
Person responsible for payment of account_____ SS#_____
Email_____

Whom may we thank for referring you? _____
Is this your child's first dental visit? _____

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

Pediatric Health History

Is your child in good health? Yes _____ No _____
Name of child's physician _____ Date of last physical exam _____

Has your child ever had a health problem? Yes _____ No _____
If yes, please explain.
_____

Has your child ever been hospitalized? Yes _____ No _____
Please give reason and dates.
_____

Is your child allergic to any medications? Yes _____ No _____

Is your child currently taking any medications? Yes _____ No _____
Please give medication, dose, and reason for taking medication.

_____
Were there any problems at birth? Yes _____ No _____

Please check if your child has been treated for any of the following:

Heart disease	Heart murmur	Tuberculosis	Problems at birth
Liver/GI disease	Kidney disease	Speech/hearing	Cerebral palsy
Tonsils/Adenoids	Skin/Eczema	Cancer/Tumors	Sickle cell anemia
Bleeding/Transfusions	Anemia	Seizures	Rheumatic fever
Headaches	Injuries	Sleep	Congenital birth defects
Asthma/Breathing	Diabetes	Hepatitis	Cleft lip/palate
Endocrine/growth	Autism	ADHD	Adverse drug reaction
AIDS/HIV	Mental delays	Physical delays	Other problems

Please explain all items checked:
_____

_____

Pediatric Dental History
Has your child been to the dentist before? Yes _____ No _____
If yes, what is the name of the dentist? _____
When was the last dental visit? _____

Has your child experienced any unfavorable reaction from previous dental care? Please explain
_____

Does your child suck a finger? _____ Thumb? _____ Pacifier? _____
Does your child have tooth pain? Yes _____ No _____
If yes, where is the pain? _____
Was your child breast fed?_____ Bottle fed? _____ Date stopped _____
Does your child sleep with a sippy cup and/or bottle? Yes _____No _____
If yes, what beverage is normally in the sippy cup and/or bottle? _____

Who helps your child brush his/her teeth? _____
How often are your child's teeth brushed? _____

Who helps your child floss his/her teeth? _____
How often are your child's teeth flossed? _____

Please check if your child currently has or has had problems with the following:

◊ Cavities	◊ Toothache	◊ Gum Infections	◊ Jaw Sounds
◊ Teeth Sensitivity	◊ Color of teeth	◊ Tooth/Face Injury	
◊ Grinds Teeth	◊ Bad Odor	◊ Orthodontics	◊ Other

Comments:
_____

_____

Fluoride History	**Yes**	**No**
Is your home water supply fluoridated?	_____	_____
Does your child use a fluoride toothpaste?	_____	_____
Does your child use a fluoride mouthrinse?	_____	_____
Do you give your child any other form of fluoride?	_____	_____
Does your child participate in a school fluoride rinse program?	_____	_____

Pediatric Consent for Dental Treatment

To the best of my knowledge, the answers I have given are accurate. I agree to report any changes to my child's medical or dental status. I give permission to the dentist to obtain additional information from my child's physician regarding medical history needed to provide dental treatment. I request and authorize Dr. Dunston, Dr. Brooks and Associates (and staff at the doctors' direction) to clean, and provide dental treatment on my child's teeth. I further request and authorize the dentist to take the necessary dental x-rays needed 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 educational 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. The dentist will provide an environment dedicated to help children learn to cooperate during treatment by using praise, explanation/demonstration of procedures, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment. I understand that my signature shall remain on file and I give my permission to Sandhills Pediatric and Family Dentistry to file my dental insurance claims on my behalf.

Signature _____ **Date** _____

Insurance Information

Name of Insured_____
Relationship to Patient_____
Date of Birth_____ Date Employed_____
SSC# _____
Employer_____
Work Phone_____
Insurance Company _____ Group #_____
Insurance Phone_____

Financial Responsibility

Payment is due at the time of service. We accept cash, debit cards, VISA, Mastercard, Discover and Care Credit as means of payment. As a courtesy, if you have dental insurance, we will file it for you. We encourage you to become familiar with the limitations of your dental plan (ie. coverage, deductibles, frequencies of procedures and co-payments), as we will collect your cost share the day of service. To avoid broken appointments and cancellation fees, we request a 24-hour courtesy call to cancel your reservation. Your account will be assessed additional fees and collection charges of 1 .5% if not paid within 30 days.

Authorization and Release

To the best of my knowledge, the above information is complete and accurate. It is my responsibility to inform Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC of any changes in my personal information (ie.telephone number, address, insurance carrier, and/or health). I understand that I am financially responsible for all charges, whether paid by insurance or not, at the time services are rendered. I authorize the use of my signature and authorize this office to submit claims and assign benefits on my behalf to _____ Insurance Company. Sandhills Pediatric and Family Dentistry, Brooks and Dunston DDS, PLLC may use my health care information and may disclose information to my Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Parent or Legal Guardian _____Date _____

Signature of Treating Dentist or Witness _____Date_____