PEDIATRIC DENTAL PROFESSIONALS

DENTAL ACQUAINTANCE RECORD (PAGE 1)

CHILD'S NAME: _____ NICKNAME: _____ SEX: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

DATE OF BIRTH: _____ AGE: _____

***WHO MAY WE THANK FOR REFERRING YOU:* _____

PARENT/GUARDIAN #1 _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____ OCCUPATION: _____ EMPLOYER: _____

CELL #: _____ WORK #: _____ EMAIL: _____

BEST CONTACT NUMBER FOR APPOINTMENT REMINDERS (circle one): ☐CELL ☐WORK OTHER: _____

PARENT/GUARDIAN #2 _____ RELATIONSHIP TO PATIENT: _____

DATE OF BIRTH: _____ OCCUPATION: _____ EMPLOYER: _____

CELL #: _____ WORK #: _____ EMAIL: _____

BEST CONTACT NUMBER FOR APPOINTMENT REMINDERS (circle one): ☐CELL ☐WORK OTHER: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO PATIENT: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

CELL #: _____ HOME #: _____ WORK #: _____

DENTAL INSURANCE INFORMATION:

INSURED'S NAME: _____ RELATIONSHIP TO PATIENT: _____

INSURANCE COMPANY: _____ INSURANCE PHONE NUMBER: _____

MEMBER ID OR SSN: _____ MEMBER DOB: _____

EMPLOYER _____ GROUP #: _____

***Insurance disclaimer:
It is our pleasure to verify dental benefits based on your individual plan. Please understand that a verification of benefits is not a guarantee of payment for services rendered. Many dental plans have waiting periods, frequency limitations and alternate benefits. We will do our best to provide you with the most accurate benefit descriptions and/or treatment plans, however, any remaining unpaid balance will become your responsibility and must be paid in a timely manner. You will have 30 days to reconcile your balance following receipt of insurance payment.

*****NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.**

Signtaure: _____ Date : _____

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DENTAL ACQUAINTANCE RECORD (PAGE 2)

CHILD'S NAME: _____

DENTAL HISTORY:	**YES**	**NO**
Is this your child's first visit to the dentist?	☐	☐
Has your child had any poor dental office experiences?	☐	☐
Does your child have any bad oral habits? (Thumb sucking, pacifier, etc.)	☐	☐
Do you desire complete and thorough dental care for your child?	☐	☐

Previous Dental Office Name: _____

Last dental examination: _____ Last dental x-rays: _____ Last topical fluoride: _____

What specific dental problems does your child have? _____

Other Comments/Concerns:_____

MEDICAL HISTORY:	YES	NO
Has your child had rheumatic fever?	☐	☐
Does your child have brain damage?	☐	☐
Does your child have seizures?	☐	☐
Is your child allergic to medication(s) or food(s)?	☐	☐
If so, Please List: _____		
Does your child have prolonged bleeding from cuts?	☐	☐
Does your child have any history of diabetes, kidney, or liver problems?	☐	☐
Does your child have any history of asthma or breathing problems?	☐	☐
If so, explain: _____		
*Has your child been to the ER for an asthma attack?	☐	☐
*What induces the breathing problems?	☐	☐
*Does your child use an inhaler or nebulizer?	☐	☐

Has your child or any of their siblings tested positive for any of the following:

☐ Hepatitis A (Infectious) ☐ Hepatitis B (Serum) ☐ HIV (AIDS)

Has your child had any history of heart trouble or a heart murmur?	☐	☐
If so, Is Antibiotic Coverage Required for dental procedures?	☐	☐

*Name of Cardiologist: _____

Pediatrician: _____ Office Phone #:_____ Last Medical Exam:_____

What are your child's current medications?: _____

Previous Hospitalizations: _____

Does your child have any physical handicaps? If so, please list:

_____

Please describe any other medical problems (mental or physical) not listed above:

_____

**I certify that the above information is true and completed to the best of my knowledge. It is my responsibility to inform the dental office of any changes in medical status. I authorize Pediatric Dental Professionals to perform a complete dental examination, dental prophylaxis (cleaning of the teeth), apply topical fluoride and take any necessary radiographs (x-rays).*

Printed Name: _____ Relationship: _____

Signature: _____ Date: _____