Jackson Pediatric Dentistry

2500 Spring Arbor Road
Jackson, MI 49203
(517) 787-1022
Fax: (517) 787-2150

Patient Information

Date _____

Name _____ Nickname _____

Home Phone _____ Patient Social Security # _____

Address _____

City _____ State _____ Zip code _____

Sex ☐ Male ☐ Female Age _____ Birthdate _____

Parent or Guardian's name _____

Whom may we thank for referring you? _____

Whom may we notify in case of an emergency? _____ Phone _____

Is child's last name different than parent(s)? _____ Who does your child live with? _____

Have any of your children been seen in this office before? _____

Father's name _____ Birthdate _____ Social Security # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip code _____ Cell Phone _____

Employed by _____ Occupation _____

E-Mail Address _____ Work phone _____

Mother's name _____ Birthdate _____ Social Security # _____

Address (if different from patient's) _____ Phone _____

City _____ State _____ Zip code _____ Cell Phone _____

Employed by _____ Occupation _____

E-Mail Address _____ Work phone _____

Does your child have dental insurance? _____

Subscriber Name _____ Birthdate _____ Social Security # _____

Insurance Co. _____ Group # _____

Subscriber Name _____ Birthdate _____ Social Security # _____

Insurance Co. _____ Group # _____

Please Complete Both Sides

Dental Health History

Reason for today's visit _____

Previous dentist _____ Address _____

Date of last dental care _____ Last dental x-rays _____

Please check (✓) if your child has had trouble with any of the following:

- ☐ Pain
- ☐ Sensitivity to Heat / Cold / Sweets
- ☐ Sensitivity when Biting
- ☐ Grinding Teeth
- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Sores or growths in your mouth

☐ Any other concerns? _____

How often does your child floss? _____ How often does your child brush? _____

Is your child nervous about dental treatment? _____ Has your child ever had a bad dental experience? _____

Does your child drink fluoridated water? ❑ Yes ❑ No Take fluoride supplements? ❑ Yes ❑ No

Medical History

Physician's name _____ Phone _____ Date of last visit _____

Previous hospitalizations, illnesses, or operations (please describe, and give approximate date) _____

_____

Any special needs? _____

Does your child require premedication before procedures due to heart or other conditions? ❑ Yes ❑ No

Has your child ever had a blood transfusion? ❑ Yes ❑ No Is your child up to date on vaccinations? ❑ Yes ❑ No

Please check (✓) if child has or has had any of the following:

- ☐ AIDS / HIV Positive
- ☐ Anemia / Blood Disease
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Autism
- ☐ Asthma
- ☐ ADD / ADHD
- ☐ Back Problems
- ☐ Birth Defects
- ☐ Cancer
- ☐ Chemotherapy / Radiation Treatment
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Shortness of Breath
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Heart Problems Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Neurologic Problems
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Mental Disabilities
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Skin Rash
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Wheelchair Requirement

Are there any medical conditions not listed above? _____

Please list any medications your child is currently taking _____

Please list any allergies _____

☐ Updated _____ ☐ Updated _____ ☐ Updated _____ ☐ Updated _____

☐ Updated _____ ☐ Updated _____ ☐ Updated _____ ☐ Updated _____

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

The policy in our office, is the parent who requests treatment for the child is responsible for all the fees for services rendered. I give my permission to Jackson Pediatric Dentistry to provide dental services and any treatment related to those services to the minor child.

Payment is due in full at time of treatment, unless prior arrangements have been approved.

Signature _____ Date _____