PARKSTON DENTAL CENTER

Date: _____

Patient Name: _____

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____

Cell Phone: _____

E-Mail Address: _____

Place of Employment: _____

Work Phone: _____

Physician's Name: _____

Physician's Phone: _____

Spouse/Parent/Guardian: _____

Emergency Contact (name and phone): _____

Person Responsible for Payment: _____

Method of Payment (Cash, Insurance, Credit Card): _____

Referred By: _____

1. This clinic accepts patient applications from all people, regardless of sex, age, race, religion, color, ethnic origin, or disability status.
2. It is important for you to keep your appointments. Please notify the office one day in advance if you are unable to keep your appointment.
3. Services are provided on a pay as you receive service basis unless other arrangements have been made in advance. Charges not covered by insurance are the responsibility of the patient. Accounts over 30 days are subject to a 1.74% finance charge.

I, the undersigned (patient or legally responsible party), authorize dental treatment and assume financial responsibility for the treatment I agree to. My signature constitutes my acceptance of these policies.

Patient/Guardian Signature: _____**Date:** _____

Patient Name: _____ Date of Birth:_____

Dental History

Is the child currently in pain? ☐ Yes ☐ No

What is the primary reason for today's visit? _____

Has the child experienced problems with previous dental work? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

□ Parent Helps □ Without Parent Help

Floss his/her teeth daily? ☐ Yes ☐ No

□ Parent Helps □ Without Parent Help

Has the child had sealants in the past? ☐ Yes ☐ No

What is the date of the last dental x-ray?_____

☐ Previous ☐ Present Dentist: _____ Date of Last Visit: _____

How do you think your child will do today?:_____

Does/did the child have any of the following habits?

☐ Yes ☐ No Lip Sucking/ Biting	☐ Yes ☐ No Clenching/Grinding Teeth	☐ Yes ☐ No Tongue/Cheek Biting
☐ Yes ☐ No Mouth Breather	☐ Yes ☐ No Nail Biting	☐ Yes ☐ No Thumb/Finger Sucking
☐ Yes ☐ No Uses/Used Pacifier	☐ Yes ☐ No Speech Problems	☐ Yes ☐ No Chewing on Objects
How many months or years_____	☐ Yes ☐ No Tongue Thrust	☐ Yes ☐ No Breast Fed
☐ Yes ☐ No Nursing Bottle Habits		

Medical History

Child's Physician: _____ Phone #:_____ Date of Last Visit:_____

Address: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No Please Explain:_____

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor Are immunizations current? ☐ Yes ☐ No

Please list all of the drugs that the child is currently taking: _____

Is your child allergic to any of the following? (please circle) Aspirin, Penicillin, Codeine, Acrylic, Metal, Latex, Local Anesthetics, Nut Allergy

Does your child have any medical conditions that require Pre-Med? ☐ Yes ☐ No

Has the child had/experienced any of the following:

☐ Yes ☐ No Abnormal Bleeding	☐ Yes ☐ No Development Delay	☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No ADD	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Anemia	☐ Yes ☐ No Down Syndrome	☐ Yes ☐ No Seizures
☐ Yes ☐ No Anaphylaxis	☐ Yes ☐ No Emotional/Psychiatric Problems	☐ Yes ☐ No Scarlet Fever
☐ Yes ☐ No Hospital Stay/operations	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Seasonal Allergies
☐ Yes ☐ No Asthma	☐ Yes ☐ No Food Allergies	☐ Yes ☐ No Sickle Cell Anemia
☐ Yes ☐ No Autism Spectrum	☐ Yes ☐ No G-Tube Feeding	☐ Yes ☐ No Skin Disorders
☐ Yes ☐ No Birth Defects	☐ Yes ☐ No Fainting Spells/Dizziness	☐ Yes ☐ No Sleep Apnea/Snoring
☐ Yes ☐ No Blood Transfusions/Blood Disease	☐ Yes ☐ No Hearing Loss/Impairment	☐ Yes ☐ No Spina Bifida
☐ Yes ☐ No Cancer	☐ Yes ☐ No Heart Condition/Murmur	☐ Yes ☐ No Stomach/Intestinal Disease
☐ Yes ☐ No Cerebral Palsy	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Tonsillitis
☐ Yes ☐ No Chemotherapy	☐ Yes ☐ No HIV/AIDS	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Chronic Ear Infections/Tubes	☐ Yes ☐ No Hyperactivity/ADHD	☐ Yes ☐ No Tumors
☐ Yes ☐ No Cold Sores/Fever Blister	☐ Yes ☐ No Kidney Disease	☐ Yes ☐ No Syndrome (Specify)
☐ Yes ☐ No Cystic Fibrosis	☐ Yes ☐ No Learning Disabilities	☐ Yes ☐ No Other
☐ Yes ☐ No Delayed Speech Development	☐ Yes ☐ No Liver Disease	
☐ Yes ☐ No Depression / Anxiety	☐ Yes ☐ No Muscular Dystrophy	

Please explain any Yes answers: _____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor to all insurance benefits. I understand that I am reponsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature:_____ Date:_____