NORTH COAST
DENTAL GROUP

Pediatric Dentistry

Today's Date: _____

PATIENT INFORMATION

Child's Name: _____ Date of Birth: _____ Gender:_____
Nickname: _____ School & Grade: _____
Address: _____ Names & Ages
_____ of Sisters : _____
Zip Code: _____ Names & Ages
Home Phone: _____ of Brothers : _____

FAMILY INFORMATION

Parent's Name: _____ Date of Birth: _____
Address: _____ Social Security # : _____
_____ Marital Status: _____
Employer: _____ Home Phone: _____
Occupation: _____ Cell Phone: _____
E-mail: _____ Work Phone: _____

Parent's Name: _____ Date of Birth: _____
Address: _____ Social Security # : _____
_____ Marital status: _____
Employer: _____ Home Phone: _____
Occupation: _____ Cell Phone: _____
E-mail: _____ Work Phone: _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE:

Subscriber's Name : _____ Date of Birth : _____
Insurance Company : _____ Employer : _____
Social Security # : _____ Employer's Address: _____
Subscriber Number : _____ _____

SECONDARY DENTAL INSURANCE:

Subscriber's Name : _____ Date of Birth : _____
Insurance Company : _____ Employer : _____
Social Security # : _____ Employer's Address: _____
Subscriber Number : _____ _____

Is there someone we may thank for recommending our office to you? _____

-OR- How did you find out about us? _____ Print Ad _____ Yellow Pages _____ Internet _____ Other

Have you or any other member of your family ever been seen in this office before? ☐ No ☐ Yes, with which doctor?

__ Dr. Medler __ Dr. Xavier __ Dr. Tavares __ Dr. Khan __ Dr. Musiker

PLEASE COMPLETE OTHER SIDE

Child's Name : _____ Age : _____ Today's Date : _____

Pediatric Medical History

1. Is your child in good health?. . . . . Yes No
2. Who is your child's physician?

   _____
3. When was your child's last physical (medical) examination? _____
4. Is your child currently under the care of any physician?. . . . . Yes No
   If yes, what is the condition being treated? _____
5. Has your child ever had a serious illness, accident, operation, or been hospitalized?. . . . . Yes No
   If yes, please explain _____
6. Has your child ever had an accident that involved teeth, face, head or neck?. . . . . Yes No
7. Is your child taking any drugs or medications including non-prescription medication?. . . . . Yes No
   If yes, what medication is your child taking? _____

8. Does your child have any of the following diseases or problems? Please circle those that apply.
   a. Damaged or artificial heart valves, **including** heart murmur or rheumatic heart disease. . . . . Yes No
   b. Asthma or hay fever . . . . . Yes No
   c. Seizures . . . . . Yes No
   d. Diabetes. . . . . Yes No
   e. Hepatitis, jaundice, or liver disease . . . . . Yes No
   f. AIDS or HIV infection or exposure to the HIV virus . . . . . Yes No
   g. Kidney trouble. . . . . Yes No
   h. Hearing or speech problem. . . . . Yes No
   i. Tuberculosis. . . . . Yes No
   j. Epilepsy or other neurological disease. . . . . Yes No
   k. Problems with mental health . . . . . Yes No
   l. Prolonged or abnormal bleeding? . . . . . Yes No
   m. Any blood disorder such as anemia?. . . . . Yes No
9. Is your child allergic to or had a reaction to:
   a. Local anesthetics . . . . . Yes No
   b. Penicillin or other antibiotic . . . . . Yes No
   c. Sulfa drugs . . . . . Yes No
   d. Latex or natural rubber. . . . . Yes No
   e. Other _____
10. Has your child ever had a negative medical or dental experience? . . . . . Yes No
    If yes, please explain _____
11. Does your child have any disease, condition or problem not listed you think we should know about?. . . . . Yes No
    Is yes, explain _____
12. Does your child smoke or use smokeless tobacco? Yes No
13. Is your child pregnant? . . . . . Yes No
14. Does your child snore or been diagnosed with Sleep Apnea . . . . . Yes No
15. Was your child born Pre-Maturely (<37 weeks). . Yes No
16. Has your child ever been in a NICU/PICU. . . . . Yes No
    Explain: _____
17. Any additional comments or concerns: _____
    _____
    _____

Dental History

18. Is this your child's first dental visit (anywhere)? .. Yes No
19. Date of last dental examination or treatment: _____
20. Are there any recent dental X-rays at another office? . . . . . Yes No
21. Is your child experiencing dental pain or discomfort? . . . . . Yes No
22. What concerns you most about your child's dental health? _____
23. What is your child's attitude towards this visit? _____
24. Does your child suck thumb(s) or finger(s)? . . . **now** ◗ Yes No . . . . . *in the past* ◗ Yes No
25. Does your child nurse from a bottle? . . . . . **now** ◗ Yes No . . . . . *in the past* ◗ Yes No
26. Does your child use a pacifier?. . . . . **now** ◗ Yes No . . . . . *in the past* ◗ Yes No

Are you this child's parent or legal guardian? . . . . . Yes No

I certify that I have read, completed, and understand both sides of this form. I acknowledge that my concerns, if any, about the inquiries set forth above, have been answered to my satisfaction. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

I grant the right to the dentist to release health information obtained from me about my child and information about my child's dental treatment to third party payers and/or other health practitioners.

_____

Signature Relationship to child Date