SHORELINE
PEDIATRIC DENTISTRY

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PATIENT INFORMATION

Today's Date: _____ Reason for today's visit: _____

A.) Tell us about your child:
Child's Name (First, Middle, Last):
_____
Nickname/Preferred Name: _____ Male / Female
Birthday (MM/DD/YYYY): _____/_____/_____ Age: _____
Child's Home #: (_____)_____
Child's Home Address:
_____
City: _____ State: _____ Zip: _____
Child's School: _____
Grade: _____
Family Members Seen Here: _____

B.) Mother's Information: Mom / Step-Mom / Guardian
Name: _____ DOB: ____/____/_____
Work: (_____)_____ Ext: _____
Cell: (_____)_____ Home: (_____)_____
SSN: _____ Employer: _____
Email: _____

C.) Father's Information: Father / Step-Father / Guardian
Name: _____ DOB: ____/____/_____
Work: (_____)_____ Ext: _____
Cell: (_____)_____ Home: (_____)_____
SSN: _____ Employer: _____
Email: _____

D.) Who is accompanying the child today?
Name: _____ Relation: _____
Do you have legal custody of this child? YES / NO
Parent's Marital Status: _____

E.) Person responsible for payment of account:
Name: _____ Relation: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Cell: (_____)_____ Home: (_____)_____
SSN: _____ Driver's License#: _____

F.) Dental Insurance:
Insured's Employer: _____
Insurance Name: _____
Insurance Phone: (_____)_____
Address: _____
Policy #: _____ Group #: _____
Policy Holder's Name: _____
SSN: _____ DOB: _____/_____/_____
Relationship to Patient: _____

G.) Referral Information: How did you hear about us?
___ Internet
___ Referred by patient/parent Who?_____
___ Referred by Dentist/Doctor Who? _____
___ Other Please List: _____

HEALTH HISTORY

Patient's Physician's Name: _____ Physician's Phone: (_____)_____
Physician's Office Name & Address: _____

YES NO Is your child in good health? Date of last physical exam (MM/DD/YYYY): _____/_____/_____
YES NO Is your child up to date on immunizations against childhood diseases?
YES NO Were there ANY problems at birth? Please describe: _____
Was your child: ☐Breast Fed ☐Bottle Fed At what age did he/she stop? _____
YES NO Has your child ever had ANY health problems? Please list: _____
YES NO Has your child EVER been hospitalized? Please give reason & dates: _____
_____
YES NO Is your child currently taking ANY medications (including over the counter)? Please list and give reason: _____
_____
YES NO Is your child allergic to anything (food/medications/dyes/latex/etc.)? Please list and describe: _____
_____
YES NO Has your child ever had a reaction to or problem with an anesthetic? Please describe: _____
_____
YES NO Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? Please list and explain:
_____

PLEASE COMPLETE BACK SIDE OF FORM ⇨

HEALTH HISTORY (CONTINUED)

Please Check If Your Child Has Been Treated For ANY Of The Following:

- ☐ ADD / ADHD
- ☐ AIDS / HIV
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Dyscrasia
- ☐ Bleeding / Transfusion
- ☐ Cerebral Palsy
- ☐ Cancer / Tumors
- ☐ Cleft Lip / Palate
- ☐ Congenital Birth Defects
- ☐ Developmental Delays
- ☐ Diabetes
- ☐ Frequent Infections
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Liver / GI Disease
- ☐ Mental Delays
- ☐ Personality / Social
- ☐ Physical Delays
- ☐ Recurrent Headaches
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Speech / Hearing
- ☐ Other

Please elaborate on ANY items checked above: _____

_____

_____

Do you consider your child to be: ☐Advanced in the learning process ☐Progressing normally ☐Slow in the learning process

YES NO **Female patients only:** Due to medications we may prescribe, it is important to know if the patient is taking any contraceptives.

YES NO **Female patients only:** Due to x-rays taken, it is important to know if the patient is pregnant or if there is ANY possibility that the patient is pregnant?

DENTAL HISTORY

YES NO Has your child ever been to the dentist? Name of dentist: _____
Date of last dental visit and x-rays: _____

YES NO Has your child experienced any unfavorable reaction from previous dental care? Please explain: _____
_____

YES NO Does your child suck a finger, thumb, or pacifier? Please elaborate: _____

Please check if your child is having problems with any of the following:

- ☐Cavities
- ☐Toothache
- ☐Jaw Sounds/Pain
- ☐Sensitive Teeth
- ☐Trauma
- ☐Gum Infections
- ☐Orthodontics
- ☐Color Of Teeth
- ☐Other: _____

FLUORIDE HISTORY

YES NO Is your home water supply fluoridated?

YES NO Does your child use a fluoride toothpaste?

YES NO Do you give your child any other form of fluoride? Please list: _____

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Field to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Field 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. Dr. Field will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature of Parent / Legal Guardian: _____ Date: _____

I give permission for the use of my child's name and picture for in-office promotions, our dental website and other social medial, and for dental advertising purposes (for example our No Cavities Club). _____ Initials of Parent / Legal Guardian