TEDDY BEAR CHILDRENS DENTISTRY

Patients Name: _____ Nickname: _____
Last name First name M.I.

Date of Birth: _____ Gender: _____

Patients Address: _____ City: _____ State: _____ Zip: _____

Parents Cell Phone: _____ E-mail: _____ Home Phone: _____

Parents Work Phone: _____ In case of emergency, contact Phone: _____

Whom may we thank for referring you? _____

Who Is Accompanying the Patient Today? Name: _____ Relation: _____

Do you have legal custody of this patient? Yes/ No If no documents are required-(Appointed by court)

Person Responsible for Account

Name: _____

Relation: _____

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ DL#: _____ SS#: _____

Who is responsible for making appointments? Name: _____ Cell Phone: _____

Primary Dental Insurance

Insurance Co Name: _____
Insurance Co Address: _____
Insurance Co Phone: _____
Group #: _____

Policy Owners Name: _____
Relationship to Patient: _____

Policy Owner Birthdate: _____ ID#: _____

Orthodontic Coverage? Yes/N

Secondary Dental Insurance

Insurance Co Name: _____
Insurance Co Address: _____
Insurance Co Phone: _____ Group #: _____

Policy Owners Name: _____
Relationship to Patient: _____

Policy Owner Birthdate: _____ ID#: _____ Orthodontic Coverage? Yes/N

Dental History

Reason for Today's Visit is: _____

Is this your child's first visit to the dentist? Yes /No

Date of Last Dental Care: _____ Date of Last X-rays: _____

Does your child have any of the following?

☐ Mouth Breather ☐ Nursing Bottle Habits

☐ Tongue Thrust ☐ Clenching/ Grinding Teeth

Speech Problems Y/N Nail Biting Y/N Thumb/Finger Sucking Y/N Lip Sucking/Biting Y/N

Does the patient brush his / her teeth daily? Yes / No

Has the patient ever had any pain / tenderness in his / her jaw joint (TMJ/TMD)? Yes / No

Has the patient ever had a serious / difficult problem associated with previous dental work? Yes / No

Has the patient ever had orthodontic treatment (braces)? Yes / No

Medical History

Is the patient currently under the care of a physician? Yes/No

Describe the patient's current physical health: Good Fair Poor

Has the patient ever been prescribed Fosamax or any other bisphosphonate? Yes / No If so, When? _____

List all prescription / over the counter or herbal supplement drugs that the patient is currently taking:

(PLEASE CHECK AT LEAST ONE (1) OF THE BOXES)

Has the patient ever had any of the following medical problems? Please check at least one of the boxes.

☐ Abnormal Bleeding	☐ Asthma	☐ Radiation/Chemotherapy	☐ Congenital Heart Defect
☐ ADD / ADHD	☐ Epilepsy	☐ Diabetes	☐ Handicaps / Disabilities
☐ Operations / Surgery	☐ Heart Murmur	☐ Hearing Impairment	☐ Hemophilia
☐ Bone Disorders	☐ Hepatitis	☐ HIV+ / AIDS	☐ Kidney / Liver Problems
☐ Asperger Syndrome	☐ Hospital Stays	☐ Tuberculosis (TB)	☐ Autism
☐ Rheumatic/Scarlet Fever	☐ Gastrointestinal Disorders	☐ Convulsions	☐ Tumors
☐ Herpes	☐ Anemia	☐ Nervous Disorder	☐ No Medical problems

Are there any Medical Conditions we have not discussed that we should be aware of:

_____

Adolescent Women:

Are you taking oral contraceptive? Y/N

Are you pregnant now or think you may be? Y/N

Are you nursing? Y/N

Allergies:

☐ Latex	☐ Penicillin
☐ Metal	☐ Food
☐ Nickel	☐ Other
☐ Plastic	☐ None

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in the patient's medical status. I hereby authorize the Dentists and staff at Teddy Bear Children's Dentistry to perform diagnostic aids including X-rays, models and photographs as appropriate to make a thorough diagnosis of the patient's dental needs. I authorize the use of this signature on all insurance submissions. I authorize the dentists to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that I will be charged 24% APR for any past due balances over 60 days. I consent Teddy Bear Children's Dentistry using my cell phone number to call and/or text regarding appointments, insurance, and my account. I understand that I can withdraw my consent at any time.

_____	_____	_____
Name of Parent or Guardian	Signature	Date
_____	_____	_____
Review Medical History/Comments	Dentist Signature	Date