

DEAN SCHWEITZER, D.D.S.
KATHLEEN A. SIU, D.M.D.
CARLA ABOUD, D.D.S.

PEDIATRIC DENTISTRY

PATIENT INTRODUCTION

Please assist us by answering all of the following questions. This confidential information is important for our records in evaluating and treating your child.

PATIENT INFORMATION

Date _____
Child's Name _____ Nickname _____ M F
Age _____ Date of Birth _____ School _____
Whom may we thank for referring you? _____

FAMILY RECORD

Residence Address _____ City _____ State _____ Zip _____
Residence Phone _____
Parent's full name _____ M F Driver's lic. # _____ Date of Birth _____
Address (if different) _____ Phone # _____
Occupation _____ Employed by _____ SS# _____
Business Address _____ Business Phone _____
Pager or Cellular Phone _____ E-Mail _____
Parent's full name _____ M F Driver's lic. # _____ Date of Birth _____
Address (if different) _____ Phone # _____
Occupation _____ Employed by _____ SS# _____
Business Address _____ Business Phone _____
Pager or Cellular Phone _____ E-Mail _____
Please list the first names of your child's brothers and sisters and their ages: _____
Has any member of your family been a patient in this office before? Yes No
If yes, please name _____

DENTAL INSURANCE

Name of insured _____ Father/Mother/Stepparent/Guardian _____
Birthdate _____ Social Security # _____
Name of Employer _____ Union or Local # _____ Work phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy ID # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
Insurance Co. Phone Number _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? If yes, complete below.

Name of insured _____ Father/Mother/Stepparent/Guardian _____
Birthdate _____ Social Security # _____
Name of Employer _____ Union or Local # _____ Work phone _____
Address of Employer _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy ID # _____
Insurance Co. Address _____ City _____ State _____ Zip _____
Insurance Co. Phone Number _____

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED FOR MY DEPENDENTS.

FINANCIAL RESPONSIBILITY

(If parents do not live together, the parent that accompanies the child will be responsible for payment at each visit.)

SIGNATURE OF PARENT X _____

DENTAL HISTORY

Child's Name _____
Reason for today's visit _____
Former Dentist _____
City / State _____
Date of last dental visit _____
Has your child had an unfavorable experience in a previous dental (medical) office? _____
Have there been any injuries to your child's teeth or jaws — falls, blows, chips, etc.? _____
Does your child receive fluoride vitamins, tablets, water, etc.? _____
Has an orthodontist seen your child? If so, who? _____
Name of family (parent's dentist): _____

CHILD'S HABITS

Does your child:

Suck his/her thumb / finger _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Suck / bite his/her lips _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Bite / chew his/her nails or hard objects _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Grind his/her teeth _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Clench his/her jaw _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____
Phone # _____ Medical Record # if applicable _____
Is your child presently under the care of a physician for any medical problem or condition? Yes No
If so, please describe _____
Is your child currently taking any medication? Yes No
Please list name and dosage _____
Has your child ever been hospitalized or had surgery? Yes No
Please describe (for what condition and when) _____

Has your child ever had any of the following:

Asthma _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Liver Disorder _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Cancer _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Kidney Disorder _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hepatitis _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Gastrointestinal Disorder _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hemophilia / Blood Disorder _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Diabetes _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Rheumatic Fever _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Congenital Heart Defect _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Heart Murmur _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Epilepsy or seizures _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Anemia _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Tuberculosis _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Red Dye Allergy _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>
ADD/ADHD _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Latex Allergy _____	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Please describe any medical problems that your child has: _____
Is your child developmentally delayed, physically handicapped, or have any learning or emotional disabilities? _____
Please describe any other medical history or problem you feel should be brought to the doctor's attention: _____

Please list your child's allergies to any medication or foods: _____

I HEREBY AUTHORIZE DR. DEAN SCHWEITZER, DR. KATHLEEN SIU OR DR. CARLA ABOUD TO PERFORM A DENTAL EXAMINATION INCLUDING DENTAL XRAYS, IF NECESSARY, FOR MY ABOVE NAMED CHILD. ANY ADDITIONAL PROCEDURES BEYOND A DENTAL CLEANING WILL BE EXPLAINED TO ME PRIOR TO INITIATION OF SUCH PROCEDURES.

SIGNATURE: _____ RELATIONSHIP TO CHILD _____ DATE _____