Monroe Pediatric Dentistry

(609) 409-0499

www.monroepediatricdentistry.com

About the Patient…

First Name _____ Last Name _____ Nickname _____

Gender: Male Female Date of Birth _____ Social Security # _____

Street Address _____ City _____ Zip Code_____

Best email address to contact/confirm: _____

Best mobile phone number to contact/confirm: _____

Hobbies, pets, favorite TV shows, etc. _____

School Attends _____

Temperament (Please circle those that apply to your child)

Shy	Fearful	Outgoing	Manipulative
Calm	Easygoing	Requires Special Understanding	

How do you think your child will act during dental treatment? _____

Is there anything else you would like us to know about your child? _____

DENTAL HISTORY

Reason for Visit _____ Previous Dentist _____

Date of Last Dental Visit _____ Date of Last Dental X-rays _____

Was the experience pleasant? Yes No Was treatment completed? Yes No

Has your child had any injury to the face or teeth? Yes No If yes, please explain _____

Does your child have any of the following habits? (circle those that apply)

Thumb/Finger Sucking	Mouth Breathing	Grinding of the Teeth	Pacifier
Tongue Thrusting	Speech Problems	Other _____	

Has your child ever taken a bottle to bed? Yes No

If yes, contents of the bottle _____ At what age was it stopped? _____

Have you nursed your child to sleep? Yes No At what age was it stopped? _____

Does your child currently drink from a bottle or a "sippy" cup? Yes No

If yes, contents of the bottle or "sippy" cup _____

Does your child drink juice, soda, other beverages containing sugar?

How often? _____

Please list snack foods _____

Does your child brush his/her teeth? Yes No How often? _____ Alone Supervised Assisted

Does your child use a fluoride toothpaste? Yes No

Does your child floss his/her teeth? Yes No How often? _____ Alone Supervised Assisted

Does your home have city water supply or well water? _____

Does your child take fluoride supplements? Yes No

Does your child drink water with fluoride? Yes No If yes, is it city or bottled? _____

Does your child take iron supplements? Yes No

MEDICAL HISTORY

Physician _____

Address _____

Phone _____

Last Physical Exam _____

Name of medications taken recently by your child (including vitamins) _____

If there are any other doctors following your child, please list their names and phone numbers on the back of this page.

We would like to send a report of your dental exam(s) to all physicians/dentists who care for your child. Please indicate here if you prefer that we NOT send a report to any of the above physicians/dentists.

Has your child ever been hospitalized or undergone surgery? Yes No

When and why? _____

Is your child adopted? Yes No

Has your child experienced severe or prolonged bleeding? Yes No

If so, please explain. _____

Is your child up-to-date with his/her immunizations? Yes No

Has your child had any type of allergic reaction to any food, medicine, or other substances? Yes No

If so, please explain. _____

Is your child allergic to penicillin, amoxicillin, any antibiotics or any other medications? Yes No

If so, please explain. _____

Has your child had any **UNUSUAL** reaction to any of the following? Please circle Yes or No.

Aspirin/Ibuprofen	Yes	No	Red Dye (any color)	Yes	No
Tylenol	Yes	No	Sulfur/Sulfa Drugs	Yes	No
Codeine	Yes	No	Latex	Yes	No
Nitrous Oxide	Yes	No	Any Metals	Yes	No
Local Anesthesia	Yes	No	Penicillin/Amoxicillin	Yes	No
General Anesthesia	Yes	No	Other _____		

Has your child **EVER** had any of the following diseases or conditions? Please circle Yes or No.

Heart Murmur	Yes	No	Celiac Disease/Gluten Sensitivity	Yes	No
Heart Problems/Defect	Yes	No	Growth Abnormalities	Yes	No
Rheumatic Fever	Yes	No	Poor Vision	Yes	No
Asthma/Wheezing	Yes	No	Speech Impairments	Yes	No
Tuberculosis	Yes	No	Hearing Difficulties	Yes	No
Hemophilia	Yes	No	AIDS/HIV	Yes	No
Kidney/Liver Problems	Yes	No	Hepatitis	Yes	No
Bleeding Disorders	Yes	No	Broken Bones	Yes	No
Anemia	Yes	No	Bone/Joint Problems	Yes	No
Sickle Cell Anemia	Yes	No	Cancer	Yes	No
Blood Transfusions	Yes	No	Congenital Birth Defects	Yes	No
Severe Infections	Yes	No	ADD/ADHD	Yes	No
Diabetes	Yes	No	Autism	Yes	No
Skin Problems	Yes	No	Emotional Difficulties	Yes	No
Epilepsy/Seizures	Yes	No	Developmental Delays	Yes	No
Fainting/Dizziness	Yes	No	Other _____		

About the Parent/Guardian...

Name of person accompanying the child _____

Relation _____

Do you have legal custody of the child? Yes No

Please note:

1. The Parent or Guardian who accompanies the patient is responsible for payment at the time of service and for the child's account, unless prior arrangements have been made.
2. If the person accompanying the child is not a parent or legal guardian, we do require that a notarized power of attorney be on file.

Mother's Information

Name _____ Date of Birth _____

Address _____

Home Phone Number _____ Mobile Phone Number _____

Work Phone Number _____ Is it ok to call or text your mobile phone? Y N

Social Security Number _____

Occupation _____ Employer _____

Business Address _____

Email Address _____

Father's Information

Name _____ Date of Birth _____

Address _____

Home Phone Number _____ Mobile Phone Number _____

Work Phone Number _____ Is it ok to call or text your mobile phone? Y N

Social Security Number _____

Occupation _____ Employer _____

Business Address _____

Email Address _____

Primary Dental Insurance

Insurance Company Name _____

Insurance Company Phone Number _____

Insurance Company Address _____

Subscriber ID Number _____ Group Number _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Social Security # _____

Policy Holder Employer _____

Secondary Dental Insurance

Insurance Company Name _____

Insurance Company Phone Number _____

Insurance Company Address _____

Subscriber ID Number _____ Group Number _____

Policy Holder Name _____ Policy Holder Date of Birth _____

Policy Holder Social Security # _____

Policy Holder Employer _____

OTHER

OTHER INFORMATION

How did you hear about us? _____

Is there someone we can thank for referring your child? _____

Your signature below certifies the following:

To the best of my knowledge the information provided is accurate and complete, and if there is a change in my child's health or medications, I will inform the doctor.

I consent to all dental treatment as well as exams, cleanings, fluoride and xrays as deemed necessary and explained to me by Dr. Lisa Sobel and/or other dental professionals.

I authorize release of information relating to a claim from Monroe Pediatric Dentistry.

I understand that I am responsible for all costs of dental treatment.

I authorize payment directly to Monroe Pediatric Dentistry from my group insurance benefits if applicable (even if my insurance policy changes).

I authorize Monroe Pediatric Dentistry to contact and provide any records and/or x-rays to my child's physicians/dentists in regards to his/her dental health.

In the event I want a copy of my child's records, I need to contact Monroe Pediatric Dentistry and obtain a records release form which I need to fill out and return to the office. I undersand that the records may not be available for up to 7 business days after I return the records release form.

Signature of Parent or Guardian _____ Date _____

Printed Name of Parent or Guardian _____

Relationship to Child _____

Doctor's Signature _____