WELCOME

PEDIATRIC DENTAL ASSOCIATES
ANDREW S HOBBS DDS

YOUR CHILD

Name _____ Age _____
Birthdate _____ Male ☐ Female ☐
Social Security # _____
Address _____
City, State, Zip _____
Phone _____

Who referred you to us? _____

MOTHER

Name _____
Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____
Employer _____
Business Address _____
Dental Ins. _____ Group # _____
Birthdate _____ Social Security # _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow

FATHER

Name _____
Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____
Employer _____
Business Address _____
Dental Ins. _____ Group # _____
Birthdate _____ Social Security # _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow

GUARDIAN

Name _____
Address _____
City, State, Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____
Employer _____
Business Address _____
Dental Ins. _____ Group # _____
Birthdate _____ Social Security # _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widow

CANCELLATION POLICY

Due to the increasing number of patients seeking dental care, it is important that you keep your child's appointment. In an effort to better serve our patients, we require a 48-hour cancellation notice. In the event that you fail to notify our office for cancellation, it may result in no future appointments for your family.

PAYMENT POLICY

If there is insurance coverage, I understand any co-payments and deductibles are due at the time of service. I am responsible for this account including any treatment expenses not covered by insurance. I authorize payment directly to Pediatric Dental Associates, P.C. of insurance benefits otherwise payable to me. If there is no insurance coverage, payment in full is due at the time of service. Exceptions may be made on a patient by patient basis. Accounts will incur a Service Charge of 1.50% after the account is 60 days old and every 30 days thereafter (to cover billing and processing).

INFORMED CONSENT

I understand that pediatric dentistry is different from adult dentistry, and some procedures and techniques may be used for my child with which I may not be familiar. Some of these include the use of nitrous oxide (laughing gas), local anesthetic (injections) and sedative medications to achieve positive behavior. I permit the use of these techniques when recommended for my child.

I am the child's: ☐ Father ☐ Mother ☐ Legal Guardian

Parent/Guardian: _____ Date: _____

Email: _____

DENTAL HISTORY

It is important we know your child's health!
Please answer all questions!

Is this your child's first dental visit? Yes ☐ No ☐

If not, when was the last visit? _____

Who was the previous dentist? _____

How does your child behave? _____

Date of last cleaning & fluoride? _____

Any toothaches or problems? _____

Any prior injuries to your child's mouth? Yes ☐ No ☐

Is your child taking fluoride drops or tablets? Yes ☐ No ☐

What is your child's attitude to dentistry? _____

HEALTH HISTORY

Child's Physician _____ Phone _____ City _____

Date of last checkup _____ Results _____

	Yes	No
Is your child taking any medications or drugs?	☐	☐
Which ones? _____		
Is your child being treated for anything?	☐	☐
Explain: _____		
Has your child ever been hospitalized?	☐	☐
Explain: _____		
Has your child ever had surgery?	☐	☐
Explain: _____		
Does your child have any allergies, including medicine or food?	☐	☐
Explain: _____		
Is your child allergic to LATEX?	☐	☐
Does your child have any emotional problems?	☐	☐
Explain: _____		
Has your child ever been diagnosed or evaluated for any handicaps or disabilities?	☐	☐
Explain: _____		
Is your child now pregnant?	☐	☐
Is your child adopted?	☐	☐

Has your child ever had any of the following? Please circle all that apply:

Seasonal Allergies

Asthma Cancer Hepatitis AIDS/HIV Hemophilia Sickle Cell Diabetes

Tuberculosis Heart Disease Rheumatic Fever Bleeding Problems Convulsions

Cerebral Palsy Heart Murmur Down Syndrome Epilepsy Kidney Disease Shunt

If you circled any of the above, is pre-medication required? Yes ☐ No ☐

Periodic Review: _____ _____ _____