Carrico&Radtke
Pediatric Dentistry

PATIENT INFORMATION

Child's Name (First/Middle/Last) _____

Birth Date _____ Social Security# _____ ☐ Male ☐ Female

Address: _____ Home#: _____

City: _____ State: _____ Zip: _____

Has any member of your family been treated in our office? ☐ No ☐ Yes

Has your child been treated by another dentist? ☐ No ☐ Yes, Dr. _____

Who may we thank for referring you to our office? _____

PARENT/GUARDIAN INFORMATION

☐ Mother ☐ Stepmother ☐ Guardian

Name (First/Middle/Last) _____

DOB: _____ SS#: _____

Drivers License #: _____

Address: _____

City/State/Zip _____

Home#: _____

Cell/Work#: _____

Employer: _____

Email: _____

☐ Father ☐ Stepfather ☐ Guardian

Name (First/Middle/Last) _____

DOB: _____ SS#: _____

Drivers License #: _____

Address: _____

City/State/Zip _____

Home#: _____

Cell/Work#: _____

Employer: _____

Email: _____

INSURANCE INFORMATION

Please notify the office of any insurance changes at each visit that may affect your account. As a courtesy, we will bill your insurance company on your behalf. You are responsible for any remaining balance.

Subscriber (First/Middle/Last) _____

DOB: _____ ID#: _____

Primary Insurance Co.: _____

Phone#: _____

Subscriber (First/Middle/Last) _____

DOB: _____ ID#: _____

Secondary Insurance Co.: _____

Phone#: _____

EMERGENCY CONTACT

Person to contact in case of an emergency other then parent/guardian.

Name: _____ Phone#: _____ Alt#: _____

Address/City/State: _____

AUTHORIZATION

I hereby authorize direct payment to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I understand that any previous balances must be paid before future care will be given. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge and may be used to contact me at anytime.

SIGNATURE OF RESPONSIBLE PARTY ☐ Mother ☐ Father ☐ Guardian ☐ Self

X _____ Date: _____

Last Name: _____ First Name: _____

DENTAL AND MEDICAL HISTORY QUESTIONNAIRE (Please answer every question.)

❑ Yes ❑ No 1. Has the child had any unusual or unpleasant experiences in a dental or medical office?

❑ Yes ❑ No 2. Has the child had any injuries to the face, mouth or teeth?

❑ Yes ❑ No 3. Was the child breast fed? How long? _____

❑ Yes ❑ No 4. Does the child have any oral habits such as thumb sucking or sleeping with a bedtime bottle?

❑ Yes ❑ No 5. Is there a chief concern regarding the child's oral health? Explain: _____

❑ Yes ❑ No 6. Is the child presently in good health?

❑ Yes ❑ No 7. Are the child's immunizations current? Child's Physician: _____

❑ Yes ❑ No 8. Has the child been in a hospital or had surgery? Describe: _____

9. Please describe any current medical treatment, pending surgery, recent injury or any other information: _____

❑ Yes ❑ No 10. Is the child taking any medications at this time? List: _____

❑ Yes ❑ No 11. Does the child attend any class or school?

❑ Yes ❑ No 12. Does the child have any abnormal behavior? Describe: _____

❑ Yes ❑ No 13. Were there any problems during pregnancy, delivery or during the child's first year of life?

❑ Yes ❑ No 14. Has the child had any unusual reaction or allergy to medications such as penicillin, aspirin, or local anesthetics?

❑ Yes ❑ No 15. Does the child have a history of allergies? List: _____

❑ Yes ❑ No 16. Is the child pregnant?

17. Do you obtain your drinking water from ❑ A Well ❑ Bottled Water ❑ A Water Purifier ❑ City Water

MEDICAL DIAGNOSIS HISTORY

❑ Yes ❑ No	ADD/ADHD	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Kidney Disease
❑ Yes ❑ No	AIDS/HIV	❑ Yes ❑ No	Ear Infections	❑ Yes ❑ No	Learning Disability
❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Liver Disease
❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Unusual Bleeding	❑ Yes ❑ No	Nutritional Problem
❑ Yes ❑ No	Autism/SID	❑ Yes ❑ No	Faintness/Dizziness	❑ Yes ❑ No	Rheumatic Fever
❑ Yes ❑ No	Behavior Problems	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Sickle Cell Disease/Trait
❑ Yes ❑ No	Birth Defects	❑ Yes ❑ No	Heart Trouble	❑ Yes ❑ No	Speech Problems
❑ Yes ❑ No	Cancer or Tumors	❑ Yes ❑ No	Hearing Problems	❑ Yes ❑ No	Tonsillitis
❑ Yes ❑ No	Cerebral Palsy	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Tuberculosis
❑ Yes ❑ No	Cognitively Impaired	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No	Vision Problems
❑ Yes ❑ No	Convulsions/Seizures	❑ Yes ❑ No	High Fevers	❑ Yes ❑ No	Other

I have updated my child's health history and understand I am responsible for any out of pocket costs. Please sign and date on line #1 for your first visit and next available line at each recall visit.

1. _____ Date
2. _____ Date
3. _____ Date
4. _____ Date
5. _____ Date
6. _____ Date
7. _____ Date
8. _____ Date
9. _____ Date
10. _____ Date

Doctors Use Only CRA: ❑ L ❑ M ❑ H Mother ❑ L ❑ M ❑ H Father ❑ L ❑ M ❑ H Sibling Order _____