# PEDIATRIC DENTISTRY & ORTHODONTICS

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PEDIATRIC DENTIST

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PEDIATRIC DENTIST - ORTHODONTIST

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PEDIATRIC DENTIST

2347 CASON STREET - LAFAYETTE, IN 47904 - 765-447-6808 - 866-315-9545 - FAX 765-447-6809

Patient Name:_____
Last First Middle

Patient Date of Birth:_____ Age_____ Sex_____

To which racial or ethnic group(s) does the patient most identify?
Whte/Caucasian____ Black/African American____ Hispanic/Latino____ Asian/Pacific Islander____ Multiracial____ Other____

Patient lives with?_____ Who is with the patient today?_____

Other family members seen by this office?_____

Who may we thank for referring you?_____ How did you hear about our office?_____

## MEDICAL HISTORY

Date of last medical examination:_____
Patient's physician/pediatrician:_____

Please mark individually
**IF YES, EXPLAIN TO THE SIDE:**

| | | |
|---|---|---|
| **GROWTH AND DEVELOPMENT** | | |
| Any learning, behavioral, excessive nervousness, or communication problems? | Y | N |
| Any history of autism? | Y | N |
| Has the patient had psychological problems? | Y | N |
| Any complications with pregnancy or childbirth? | Y | N |
| Any problems with physical growth? | Y | N |
| **CENTRAL NERVOUS SYSTEM** | | |
| Any history of cerebral palsy, seizures, convulsions, fainting, or loss of consciousness? | Y | N |
| Any history of injury to the head? | Y | N |
| Any sensory disorders? (seeing, hearing) | Y | N |
| **CARDIOVASCULAR SYSTEM** | | |
| Any history of congenital heart disease, heart murmur, or heart defect? | Y | N |
| Has any heart surgery been done or recommended? | Y | N |
| **CIRCULATORY AND LYMPHATIC SYSTEMS** | | |
| Has the patient ever had a blood transfusion or blood product transfusion? | Y | N |
| Any history of anemia or sickle cell disease? | Y | N |
| Does the patient bruise easily or bleed excessively? | Y | N |
| Is the patient more susceptible to infections than others? | Y | N |
| **RESPIRATORY SYSTEM** | | |
| Any history of pneumonia, tuberculosis, cystic fibrosis, asthma, shortness of breath, or difficulty breathing? | Y | N |
| **GASTROINTESTINAL SYSTEM** | | |
| Any history of stomach, intestinal, or liver problems? (hepatitis, jaundice) | Y | N |
| Any history of eating disorders? (anorexia, bulimia) | Y | N |
| **GENITOURINARY SYSTEM** | | |
| Any history of urinary tract infection, bladder, or kidney problems? | Y | N |
| Is the patient pregnant or possibly pregnant? | Y | N |
| **ENDOCRINE SYSTEM** | | |
| Any history of diabetes? | Y | N |
| Any history of thyroid or glandular disease? | Y | N |
| **SKIN** | | |
| Any history of skin problems? | Y | N |
| Any history of canker or cold sores? | Y | N |
| **EXTREMETIES** | | |
| Any limitations of use of arms or legs? | Y | N |
| Any arthritis, joint replacements, or joint problems? | Y | N |
| Any problems with muscle weakness or muscular dystrophy? | Y | N |
| **ALLERGIES** | | |
| Is the patient allergic to any medications? If so, which:_____ | Y | N |
| Any hay fever, hives, or skin rashes caused by allergies? Any other allergies?_____ | Y | N |

**MEDICATIONS OR TREATMENTS**

Please list any medications the patient is currently taking and what it is taken for:

| Medication | Use |
|---|---|
| | |
| | |

| | | |
|---|---|---|
| Has the patient ever received chemotherapy or been diagnosed with cancer? | Y | N |
| Is the patient on birth control medication? | Y | N |

**HOSPITALIZATIONS**

Has the patient been hospitalized? If so, when and for what reason:

_____

_____

**IMMUNIZATIONS**

| | | |
|---|---|---|
| Are the patient's immunizations up to date? | Y | N |

**GENERAL HEALTH**

| | | |
|---|---|---|
| Does the patient use tobacco products (cigarettes, snuff, chewing tobacco, bidis)? | Y | N |
| Does the patient live with someone who smokes? | Y | N |
| Does the patient have a medical condition requiring special needs? | Y | N |
| Does the patient require a pre-op antibiotic before dental procedures? | Y | N |

Please check any of the following that the patient has now, has recently been exposed to, or had in the past:

| | Now | Exposed | Past | Never |
|---|---|---|---|---|
| Chicken Pox | ____ | ____ | ____ | ____ |
| Ear Infection | ____ | ____ | ____ | ____ |
| Eye Infection | ____ | ____ | ____ | ____ |
| Head Lice | ____ | ____ | ____ | ____ |
| German measles or 3-day measles | ____ | ____ | ____ | ____ |
| Infectious mononucleosis | ____ | ____ | ____ | ____ |
| HIV/AIDS | ____ | ____ | ____ | ____ |
| Measles | ____ | ____ | ____ | ____ |
| Mumps | ____ | ____ | ____ | ____ |
| Tonsillitis / Pharyngitis | ____ | ____ | ____ | ____ |
| Substance abuse, drug addiction | ____ | ____ | ____ | ____ |
| Tuberculosis | ____ | ____ | ____ | ____ |
| Upper respiratory infection or common cold | ____ | ____ | ____ | ____ |

**DENTAL HISTORY**

Date of last dental visit:_____

Previous dentist:_____

What was done at the last visit?_____

| | | |
|---|---|---|
| Does the patient have a toothache or an immediate dental problem? | Y | N |
| Has the patient ever had a toothache? | Y | N |
| Has the patient had an injury to the mouth, teeth, or jaw? | Y | N |
| Has the patient had an unfavorable dental experience? | Y | N |
| Is/was the patient nourished by nursing beyond one year of age? | Y | N |

If so, check: Breast____ Nursing bottle____ To what age?____

**DENTAL DISEASE PREVENTION**

How often does the patient brush? ____times per day

| | | |
|---|---|---|
| Does the patient use dental floss? | Y | N |
| Does someone assist the patient with brushing? | Y | N |
| Does the patient use a fluoride toothpaste? | Y | N |
| Has the patient ever had a fluoride treatment? | Y | N |
| Has the patient ever taken a fluoride supplement? | Y | N |

Drinking water source: City water____ Private well____

**SIGNATURE** (parent / legal guardian)_____

## PARENT / GUARDIAN INFORMATION

**Mother / Guardian**

Name_____ Birthdate____/____/____
Last First Middle

Street Address_____

Post Office Box (if applicable)_____

City_____ State_____ Zip_____

Home Phone (___)_____ Work Phone (___)_____

Social Security # ___-___-___ Cell Phone (___)_____

Employer_____

Employer Address_____

Bank_____ Email_____

Insurance Coverage? Y N Primary / Secondary

**Father / Guardian**

Name_____ Birthdate____/____/____
Last First Middle

Street Address_____

Post Office Box (if applicable)_____

City_____ State_____ Zip_____

Home Phone (___)_____ Work Phone (___)_____

Social Security # ___-___-___ Cell Phone (___)_____

Employer_____

Employer Address_____

Bank_____ Email_____

Insurance Coverage? Y N Primary / Secondary

Parent marital status: Single Married Separated Divorced Widowed

**Informed Consent:**
I authorize Ditto and Sammons Dentistry Partnership to perform the necessary dental services and radiographs that my child may need. If dental services dictate, the use of mild sedation (nitrous oxide) may be used. In addition, devices used to assist in delivering proper treatment may also be utilized, such as rubber dams (isolation "raincoat") or mouth props. In the event that I have dental insurance, I authorize the release of any information obtained from the examination and treatment, and permit payment directly to Ditto and Sammons Dentistry Partnership. I understand that the filing of dental claims is done as a courtesy, but does not guarantee payment. I acknowledge and accept full financial responsibility for all services rendered, regardless of insurance. In the event of default, I understand the balance due may be placed with a collection agency or an attorney, and I agree to pay a 50% collection fee. In the event of legal action, I agree to pay reasonable attorney fees and court costs.

Signature of Mother/Guardian_____ Date_____

Signature of Father/Guardian_____ Date_____

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John Patangan DMD
Pediatric Dentist

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*You May Refuse to Sign This Acknowledgment*

**I have received a copy of this office's Notice of Privacy Practices.**

**Print PATIENT Name** _____

PARENT/GUARDIAN SIGNATURE _____

Date: _____

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____