LAFAYETTE PEDIATRIC DENTISTRY & ORTHODONTICS

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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?	Y	N
If so, which:_____		
Any hay fever, hives, or skin rashes caused by allergies?	Y	N
Any other allergies?_____		

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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Acknowledgement

This office's Notice of Privacy Practices has been made available to me.

Patient Name _____Date_____

Parent/Guardian Signature_____

For Office Use Only

An attempt was made to obtain written acknowledgement of availability of the Notice of Privacy Practices. Acknowledgement could not be obtained due to the following:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented obtaining the acknowledgement
- Other (Please Specify)
- _____
  _____
  _____