WELCOME

Children's Dentistry of Pocatello

1246 Yellowstone Ave., Suite B-3, Pocatello, ID 83201 (208) 238-1165

Today's Date:_____ Child's Home Phone#:(__)_____ Social Security #:_____

Child's Name:_____ Child's Birthdate:___/___/___ Child's Age:_____

Nickname:_____ __ Male __ Female School:_____ Grade:_____

Child's Home **Adress:**_____
Street **City** **State** **Zip**

Whom may we thank for referring you?_____

E-mail Address:_____

Parent's Marital Status: __Married__Divorced__Separated__Widowed__Remarried__Single__Partnered

Mother Birthdate:___/___/___ Home #:(___)_____ Work #:(___)_____ Cell#:(___)_____

Name:_____ Social Security #:_____ Driver's License#:_____

Address:_____
Street City State Zip

Employer:_____ Length of Employment:_____

Father Birthdate:___/___/___ Home#:(___)_____ Work#:(___)_____ Cell#:(___)_____

Name:_____ Social Security#:_____ Driver's License#:_____

Adress:_____
Street City State Zip

Employer:_____ Length of Employment:_____

Primary Insurance Dental Coverage? __Yes__No Orthodontic Coverage? __Yes __No

Insurance Co. Name:_____ Phone #:(___)_____ Group #(plan, Local, Policy)_____

Insurance Co. Address:_____
PO Box/Street City State Zip

Insured's Name:_____ Relationship to patient:_____

Insured's Birthdate: ___/___/___ Social Security #:_____ Insured's Employer:_____

Employer's Address:_____
Street City State Zip

Secondary Insurance Dental Coverage? __Yes __No Orthodontic Coverage? __Yes __No

Insurance Co. Name:_____ Phone #:(___)_____ Group #(Plan, Policy)_____

Insurance Co. Address:_____
PO Box/Street City State Zip

Insured's Name:_____ Relationship to patient:_____

Insured's Birthdate:___/___/___ Social Security #:_____ Insured's Employer:_____

Employer's Address:_____
PO Box/Street City State Zip

Dental & Medical History

Is the child currently in pain? ☐ Yes ☐ No Reason for today's visit? _____
Has child been previously treated for dental decay? ☐ Yes ☐ No
Does child brush his/her teeth daily? ☐ Yes ☐ No Previous/Present Dentist? _____
Does child floss daily? ☐ Yes ☐ No
Does either parent have history of dental carries? ☐ Yes ☐ No
Does child have siblings with history of dental carries? ☐ Yes ☐ No

What type of toothpaste does child use?_____

Does/did the child have any of the following habits?

☐ Lip sucking/biting	☐ Clenching/Grinding teeth	☐ Tongue/Cheek biting	☐ Mouth Breather
☐ Nail biting	☐ Thumb/finger sucking	☐ Used pacifier	☐ Speech problems
☐ Chewing on objects	☐ Nursing bottle habits	☐ Tongue thrust	☐ Breast fed
☐ Sleep with bottle	☐ Drink pop regularly	☐ Drink juice regularly	

Did mother have any complications during pregnancy? Please explain:_____

Did mother take any medications during pregnancy? Please explain:_____

When was the child weaned from a bottle?_____

Was the child ill during infancy? Please explain:_____

Is the child currently under the care of a physician? ☐ Yes ☐ No Please explain:_____

Please list all the drugs the child is currently taking:_____

Child's Physician:_____ Phone #(___)_____ Date of last visit:___/___/___

Address:_____
Street City State Zip

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor Are Immunizations current? ☐ Yes ☐ No
Besides the following, please list all drugs and/or things that cause the child allergic reactions:
Latex? ☐ Yes ☐ No Metals? ☐ Yes ☐ No Plastic? ☐ Yes ☐ No Penicillin? ☐ Yes ☐ No Tetracycline? ☐ Yes ☐ No

_____

_____

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Has the child had/experienced any of the following:

☐ Abnormal bleeding	☐ Chicken Pox	☐ Heart Murmur-innocent	☐ Mitral Valve Prolapse
☐ ADHD	☐ Cleft Lip/Palate	☐ Heart Murmur-premed	☐ Mononucleosis
☐ AIDS/HIV+	☐ Congenital Heart Defect	☐ Hemophilia	☐ Psychiatric Problems
☐ Allergies	☐ Convulsions	☐ Hepatitis	☐ Rheumatic Fever
☐ Anemia	☐ Diabetes	☐ High Blood Pressure	☐ Scarlet Fever
☐ Any Hospital Stay/Op.	☐ Down Syndrome	☐ Hives	☐ Seizures
☐ Asthma	☐ Epilepsy	☐ Kidney Problems	☐ Sickle Cell Anemia
☐ Autism	☐ Frequent Headaches	☐ Liver Problems	☐ Skin Rash
☐ Blood Transfusion	☐ Handicaps/Disabilities	☐ Low Blood Pressure	☐ Tonsilitis
☐ Cancer	☐ Hearing Impairment	☐ Lupus	☐ Tuberculosis (TB)
☐ Cerebral Palsy	☐ Measles		

Please discuss any serious medical problems the child experiences/ed:_____

_____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Hugues and the dental team to examine, clean and provide dental treatment on my child's teeth. I further authorize the taking of dental x-rays as may be considered necessary by Dr. Hugues to diagnose and/or treat my child's dental problem. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____ _____
Signature Date