Welcome to Desert Ridge Pediatric Dentistry.

We want to provide only the safest and most comprehensive dental care available, so we ask that you please complete this medical form as accurately as possible.

Date: _____

Patient's Name: _____ Date of Birth: _____ Gender: M ☐ F ☐

Preferred Name: _____ Favorite Hobby: _____ Home Phone: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

How did you hear about our office? _____

Do you have any questions or concerns? _____

Please list any siblings seen here: _____

Medical History

Does your child have, or has had, any of the following diseases or problems:

	Yes/No			Yes/No	
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐
Heart Abnormalities or Murmurs	☐	☐	Abnormal Bleeding	☐	☐
Asthma or Hay Fever	☐	☐	Blood Transfusions	☐	☐
Hives or Skin Rashes	☐	☐	Anemia	☐	☐
Fainting Spells or Seizures	☐	☐	Sickle Cell Anemia	☐	☐
Diabetes	☐	☐	Radiation Therapy	☐	☐
Hepatitis	☐	☐	Allergies to Medications	☐	☐
Congenital Birth Defects/Syndrome	☐	☐	Latex Allergy	☐	☐

Does your child have any disease, condition or problem not listed above that you think we should know about?

_____

Is the patient currently under the care of a physician? ☐ Yes ☐ No If so, for what? _____

Please list the name and phone numbers of any treating physicians:

_____

Is your child taking any medications? ☐ Yes ☐ No

If yes, please list: _____

Is your child allergic or has your child ever had an adverse reaction to a specific medication? ☐ Yes ☐ No

If yes, please list: _____

Dental History

Any serious trouble associated with previous dental treatment? _____

Has your child ever suffered from any of the following dental problems?

	Yes/No		Yes/No
Bad Breath	☐ ☐	Dental Infection or Abscess	☐ ☐
Bleeding Gums	☐ ☐	Pain from Teeth	☐ ☐
Discolored Teeth	☐ ☐	Missing or Extra Teeth	☐ ☐
Cold Sores or Fever Blisters	☐ ☐	Injury or Trauma to Teeth	☐ ☐

Does your child have thumb, finger or pacifier habits? ☐ Yes ☐ No

Are there any additional medical or dental concerns that you would like to discuss with the doctor during today's dental appointment?
Yes ☐ No ☐

If yes, please explain: _____

Person(s) Responsible for Account

Mother's Information ☐ **Mother** ☐ **Stepmother** ☐ **Legal Guardian** ☐ **Grandmother**

Name: _____ Date of Birth: _____

Select Yes if Address is same as Child's: ☐ Yes

Address: _____

City: _____ State: _____ Zip Code: _____

How long at this address? _____ Home Phone: _____ Email: _____

Work Phone: _____ Cell Phone: _____ Occupation: _____

Employer: _____ SSN/ID #: _____

Marital Status: ☐ M ☐ D ☐ S

Father's Information ☐ **Father** ☐ **Stepfather** ☐ **Legal Guardian** ☐ **Grandfather**

Name: _____ Date of Birth: _____

Select Yes if Address is same as Child's: ☐ Yes

Address: _____

City: _____ State: _____ Zip Code: _____

How long at this address? _____ Home Phone: _____ Email: _____

Work Phone: _____ Cell Phone: _____ Occupation: _____

Employer: _____ SSN/ID #: _____

Marital Status: ☐ M ☐ D ☐ S

Emergency Contact

In case of an emergency where neither parent nor legal guardian can be reached, please provide whom we may contact.

Name: _____ Relation: _____

Phone: _____

Dental Insurance Information

Phone Number: _____ Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Group #: _____ Local #: _____ Policy #: _____

Primary Person on this Policy: _____ SNN/ID #: _____

If you have dual insurance, please provide the information below:

Phone Number: _____ Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Group #: _____ Local #: _____ Policy #: _____

Primary Person on this Policy: _____ SNN/ID #: _____

Medical/Dental Release Statements

I give my consent for the doctors of DRPD to complete a thorough examination on the patient previously named, including any needed diagnostic radiographs. To the best of my knowledge, the information that I have provided is correct and I understand that I will be held in the strictest of confidence and in accordance to all state and federal HIPPA regulations. I also understand that it is my responsibility to inform DRPD of any changes to my child's medical status.

Release for Filing Insurance Claims & Financial Responsibility Statement

I authorize the release of information to my child's dental insurance company. I am aware that DRPD will be providing an estimate of insurance coverage prior to initiating any future treatment and that I am legally responsible for any portion not paid by this policy. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 30 days of receiving such treatment.

Authorization for Direct Payment

I hereby authorize payment of insurance benefits directly to Desert Ridge Pediatric Dentistry. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this event.

Signature of Parent or Guardian: _____ **Date:** _____

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