TOM KELLER, DDS
pediatric dentistry

Child's legal name _____ **Nickname**_____ **Sex F ( ) M ( )**

Date of Birth _____ **Age** _____ **Name of School** _____

Reason for visit _____ **Referred by** _____

Child lives with: both parents mother father other:_____

Home address _____ **City/ zip** _____

Home Phone_____ **Cell Phone**_____ **e-mail**_____

Siblings _____ **Best way to contact you: home cell work e-mail**

Father (full name) _____ **SSN:** _____ **DOB:** _____

Address (if different) _____ **City/zip**_____

Employer _____ **Work/Cell Phone** _____

Mother (full name) _____ **SSN:** _____ **DOB:** _____

Address (if different) _____**City/zip** _____

Employer _____ **Work/Cell Phone** _____

Financial Responsibility and Authorization

Person financially responsible for child's account _____ **Relationship to Child** _____

Address/City/State/Zip_____**Social Security**_____

Financial Policies: Payment is expected for services rendered at the time when those services are rendered. Financial arrangements for subsequent treatment may be made following the diagnosis and treatment plan. A $50.00 fee will be assessed when an appointment is canceled without 24 hours notice. A $27.00 fee is charged for a returned check. Interest will apply to any unpaid balance over 30 days. If an account is delinquent for 90 days or more, interest and all collection fees incurred by our office will be applied to the outstanding balance and charged to the financially responsible party.
We will be glad to do everything legally possible to assist you in receiving insurance benefits, but ultimately you and not your insurance carrier are financially responsible.

As a new patient, a financial history is not yet established with this practice. Therefore I agree to pay for today's charges as follows:
( ) Cash or Check ( ) Visa/Mastercard/Discover ( ) I will furnish insurance and agree to pay my portion today

My signature below indicates that I accept financial responsibility for this account and I acknowledge the financial policies outlined above:

Signature _____ **Date** _____

Dolphin Pediatric Dentistry **HEALTH HISTORY**

Child's Name: _____ Date: _____

Medical

Child's Pediatrician or Physician _____ *Would you like a referral for a pediatrician? Y N*

Person to contact in case of emergency _____ Telephone # _____

Has your child had any of the following medical problems? *Circle Yes (Y) or (N).*

Allergies to drugs or foods	Y N	Developmental Delay	Y N	Hepatitis	Y N
Asthma or lung problems	Y N	Diabetes	Y N	High Fevers	Y N
Attention Deficit Disorder	Y N	Down's Syndrome	Y N	HIV+/ AIDS	Y N
Autism/ PDD	Y N	Ear Infections	Y N	Hospital Stays/ Operations	Y N
Blood Transfusions	Y N	Handicaps or disabilities	Y N	Learning Disabilities	Y N
Cancer	Y N	Heart Defect (congenital)	Y N	Rheumatic Fever	Y N
Cerebral Palsy	Y N	Heart Murmur	Y N	Trauma to mouth or face	Y N
Convulsions or Epilepsy	Y N	Hemophilia or abnormal bleeding	Y N	Tuberculosis	Y N

Other medical problems: _____

Please discuss problems further, if necessary:_____

_____

Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics? Y N explain:_____

Is your child currently taking any medications? Y N What kind? _____

Is your child taking any supplemental fluoride Y N If yes, how? *Please circle* tablets, drops, water, vitamins

Does your child have any breathing problems? Y N Breathes primarily through: nose or mouth *(please circle)*

Does your child snore? Y N

Child's Dental History

Has your child seen a pediatric dentist before? Y N When? _____Where? _____

Has your child had an unfavorable experience in a dental or medical office? Y N

Does your child presently have any dental problems? Y N If yes, please explain:_____

How often does your child brush his/ her teeth per day? _____ Do you help? Y N

How often does your child floss his/ her teeth per day? _____ Do you help? Y N

How do you think your child will act toward the dentist? _____

Habits

Does your child have any of the following habits?

Thumb or finger sucking?	Y N	Pacifier Use?	Y N	Nail Biting?	Y N
Lip sucking or biting?	Y N	Biting hard objects?	Y N	Tooth Grinding?	Y N

Did your child use a bottle? Y N If yes, when did s/he stop? _____

Does your child currently use a bottle? Y N If yes, how often during the day? _____

Is the bottle used at night? Y N What do you put in the bottle? _____

Does your child currently breastfeed? Y N

Family Dental History *(Please circle appropriate parent, if yes)*

Has Mother or Father had a lot of decay? Has Mother or Father had orthodontic care?

Does Mother or Father have periodontal disease? Does Mother or Father have TMJ problems?

Would you like a general dentist referral? Y N

Consent to Treat Minor

My signature below indicates that I give permission to Dr. Keller &/or his associates to examine my child, use x-rays, photographs, cleaning & fluoride (when necessary) to properly diagnose and record any and all dental conditions.

Signature of Parent or Legal Guardian _____ Date:_____

Medical Updates

Date:	Date:	Date:	Date:
Comments:	Comments:	Comments:	Comments: