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Pediatric Dentistry of Central Ohio

NEW PATIENT FORM

Patient Information

Patient first name: _____ Middle name: _____ Last name: _____

Patient date of birth: _____ Gender: ☐ Female ☐ Male ☐ Other

Patient's home address: _____

Siblings that we treat: _____

Has your child been to the dentist before? ☐ Yes ☐ No

If yes, what office did they go to: _____

Contact Information

Mother's name: _____ Mother's date of birth: _____

Address: _____

Mobile #: _____ Work #: _____

Mother's email address: _____

Mother's SSN: _____

Father's name: _____ Father's date of birth: _____

Address: _____

Mobile #: _____ Work #: _____

Father's email address: _____

Father's SSN: _____

Emergency Contact

Emergency contact: _____ Emergency #: _____

Family doctor: _____ Family doctor #: _____

Financial Responsibility

Please indicate who will be financially responsible for this account.

☐ Mother ☐ Father ☐ Other _____

Responsible party address: _____

Responsible party #: _____

Dental Information

☐ Do your gums bleed when you brush or floss? ☐ Are you currently experiencing dental pain or discomfort?

☐ Are your teeth sensitive to cold, hot, sweets, or pressure? ☐ Do you have earaches or neck pains?

☐ Do you have any clicking, popping or discomfort in your jaw? ☐ Do you grind your teeth?

☐ Have you ever had orthodontic (braces) treatment? ☐ Do you have any sores or ulcers in your mouth?

☐ Do you drink fluoridated water? ☐ Have you ever had a serious injury to your head, neck or mouth?

Medical Information

Allergies

☐ Acetaminophen/Tylenol® ☐ Aspirin ☐ Erythromycin ☐ Fluoride ☐ Food ☐ Hay fever/seasonal

☐ Ibuprofen/Motrin®/Advil® ☐ Latex ☐ Local anesthetic ☐ Metals ☐ Penicillin ☐ Sulfa ☐ Tetracycline

☐ Other _____

Health Conditions

☐ Abnormal/excessive bleeding ☐ ADD ☐ ADHD

☐ AIDS or HIV infection ☐ Anemia ☐ Anxiety ☐ Asthma ☐ Autism

☐ Blood disease ☐ Blood transfusion ☐ Breathing problems/ respiratory disease

☐ Cancer/chemotherapy/ radiation treatment ☐ Cardiovascular disease ☐ Damaged heart valves ☐ Diabetes ☐ Down Syndrome

☐ Eating disorder ☐ Epilepsy ☐ Fainting spells or seizures ☐ Frequent headaches ☐ G.E. Reflux/persistent heartburn

☐ Hearing difficulties ☐ Heart murmur ☐ Heart rhythm disorder ☐ Hemophilia ☐ Hepatitis, jaundice or liver disease

☐ High blood pressure ☐ Kidney problems ☐ Low blood pressure ☐ Malnutrition ☐ Mitral valve prolapse

☐ Neurological disorders ☐ Other congenital heart defects☐ Psychiatric care ☐ Rheumatic fever ☐ Rheumatic heart disease

☐ Severe headaches/migraines ☐ Sinus trouble ☐ TMJ Disorder ☐ Trisomy 21 ☐ Tuberculosis ☐ Ulcers

☐ Other _____

Please indicate if you have experienced or if you are experiencing any of the following.

☐ Have you had a serious illness, operation or been hospitalized in the past 5 years? _____

☐ Has there been any changes to your general health within the past year? _____

☐ Are you taking any prescriptions or over-the-counter medicines? _____

☐ Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? _____

☐ Do you have sleep apnea?

☐ Are you pregnant?

☐ Are you taking birth control or hormone replacement?

☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? _____

Disclaimer and signature

☐ Acknowledged HIPAA regulations ☐ Acknowledged practice privacy practices

BROKEN APPOINTMENT POLICIES:
A charge of $30.00 is made for hygiene appointments that are missed, cancelled or rescheduled when less than 24 hours' notice is given. The charge will be $50.00 for a treatment appointment.

FINANCIAL POLICIES:
Payment for professional services is due at the time dental treatment is provided. If your insurance has copays and/or a deductible, the estimated amount will be collected at the time of service. If you do not have dental insurance, the full amount will be collected at the time of service. Past due accounts are subject to $5.00 monthly billing fees until the account is paid in full. Delinquent accounts are also subject to collection action after four failed attempts to collect the debt. In the event that your family account is submitted to our collection agency, the patient doctor relationship will be terminated. We will transfer any records upon your request.

Please read the above and understand that the information provided in this form is accurate. A truthful health history will help ensure the best possible dental treatment. The information provided here will be used by the doctor and patient to inform any further discussion of the patient's health prior to or during an appointment. By signing below, you also acknowledge that you will not hold the dentist, the dental practice or any other member of the practice staff responsible for any action or lack of action because of errors or omissions that may have been made during the completion of this form.

Signature: _____ Date: _____