Pediatric Medical History

Child's legal name: ___________________________ Preferred name: ________________________________ Date of birth: _____ /_____ /_____
Birth Sex: ☐ M ☐ F Current gender identity: ___________ Pronouns: __________ Race/Ethnicity:__________ SS: ________________
Name/age and relationship of others living in the household: ____
Primary physician: ______________________________ Address/phone: _________________________ Last visit: _______________________

Mother's legal name: ______________________________________ SS#: ___________________________________ Date of birth: ____/____/_______
Phone:_______________ Email: __________________________ Address: ______________________________ Employer: _______________________
Father's legal name: ______________________________________ SS#: ___________________________________ Date of birth: ____/____/_______
Phone:_______________ Email: __________________________ Address: ______________________________ Employer:_______________________

Who is accompanying the child today?
Name: ______________________ Relation: ______________ Parent's Marital Status: _______________ Do you have custody of this child? YES / NO

Referral Information: How did you hear about us?
☐ Website ☐ Referred by patient/parent. Who? __________________ ☐ Mailer
☐ Referred by dentist/Doctor. Who? __________________ ☐ Other (Please list) _____________________________

Dental Insurance
Insured Employer: ____________________________________ Insurance Name: _______________________________________
Insurance Address & Phone Number: ____
Group #: _____________________ Policy #: _____________________ Policy Holder Name: ______________________________
SS#: ________________________________ DOB:________________ Relationship to Patient: _________________________________

Is your child being treated by a physician at this time? Reason____	☐ YES	☐ NO
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?	☐ YES	☐ NO
List name, dose, frequency & date started: ____		
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?	☐ YES	☐ NO
List date & describe: ____		
Has your child ever had a reaction to, or problem with an anesthetic? Describe ____	☐ YES	☐ NO
Have you been told your child needs antibiotics or another medicine before dental treatment? Reason _____________________	☐ YES	☐ NO
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _________________________	☐ YES	☐ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of these conditions applies to your child.

Complications before or at birth, prematurity, inherited conditions, syndromes, or birth defects (such as cleft lip/palate, MTHFR Deficiency)	☐ YES	☐ NO
Problems with physical growth or development	☐ YES	☐ NO
Sinusitis, chronic adenoid/tonsil infections	☐ YES	☐ NO
Sleep apnea, snoring, or mouth breathing	☐ YES	☐ NO
Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	☐ YES	☐ NO
Irregular heart beat or high blood pressure	☐ YES	☐ NO
Asthma, reactive airway disease, wheezing, or breathing problems	☐ YES	☐ NO
Cystic fibrosis	☐ YES	☐ NO
Frequent exposure to tobacco smoke	☐ YES	☐ NO
Jaundice, hepatitis, or liver problems	☐ YES	☐ NO

PROVIDE DETAILS HERE: ____
____
____
____

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of these conditions applies to your child.

Condition	YES	NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intenstinal problems	☐ YES	☐ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐ YES	☐ NO
Prolonged diarrhea, unintenional weight loss, concerns with weight, or eating disorder	☐ YES	☐ NO
Bladder or kidney problems	☐ YES	☐ NO
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis	☐ YES	☐ NO
Rash/ hives, eczema, or skin problems	☐ YES	☐ NO
Impaired vision, visual processing, hearing, or speech	☐ YES	☐ NO
Developmental disorders, learing problems/ delays, or intellectual disability	☐ YES	☐ NO
Cerebral palsy, brain injury, concussion, epilepsy, or convulsions/seizures	☐ YES	☐ NO
Autism/autism spectrum disorder or sensory integration disorder	☐ YES	☐ NO
Recurrent or frequent headaches/ migranes, fainting, or dizziness	☐ YES	☐ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)	☐ YES	☐ NO
Attention deficit/hyperactivity disorder (ADD/ADHD)	☐ YES	☐ NO
Behavioral, emotional, communication, or psychiatric problems/treatment	☐ YES	☐ NO
Diabetes, hyperglycemia, or hypoglycemia	☐ YES	☐ NO
Thyroid or pituitary problems	☐ YES	☐ NO
Anemia, sickle cell disease/trait, or blood disorder	☐ YES ☐	☐ NO ☐
Hemophilia, bruising easily, or excessive bleeding	☐ YES	☐ NO
Transfusions or receiving blood products	☐ YES	☐ NO
Cancer, tumor, or other malignancy; chemotherapy, radiation therapy, or bone marrow or organ transplant	☐ YES	☐ NO
Corona virus disease 2019 (COVID-19), cytomegalovirus (CMV), human immunodeficiency virus (HIV)/AIDS, methicillin-resistant staphylococcus aureus (MRSA), mononucleosis, scarlet fever, or tuberculosis (TB)	YES	NO

PROVIDE DETAILS HERE: ____

____

____

Is there any other signifcant medical history pertaining to this child or the child's family that the dentist should be told? ☐ YES ☐ NO

If YES, describe ____

____

____

What is your primary concern about your child's oral health? ____

____

How would you describe your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is there a family history of caveties? ☐ YES ☐ NO If yes, indicate all that apply: ☐ Mother ☐ Father ☐ Brother ☐ Sister

Does your child have a history of any of the following? For each YES response, please describe:

Condition	YES	NO	Description
Inherited dental characteristics	☐ YES	☐ NO	______________________
Mouth sores or fever blisters	☐ YES	☐ NO	______________________
Bad breath	☐ YES	☐ NO	______________________
Bleeding gums	☐ YES	☐ NO	______________________
Cavities/decayed teeth	☐ YES	☐ NO	______________________
Toothache	☐ YES	☐ NO	______________________
Injury to teeth, mouth, or jaws	☐ YES	☐ NO	______________________
Clinching/grinding teeth	☐ YES	☐ NO	______________________
Jaw joint problems (popping, etc.)	☐ YES	☐ NO	______________________
Excessive gagging	☐ YES	☐ NO	______________________
Sucking habit after one year of age	☐ YES	☐ NO	If YES, how long? ___________ Which? ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other

How often are your child's teeth brushed? ____________ times per____________ Does someone help your child brush? ☐ YES ☐ NO

How often are your child's teeth flossed? ☐ Never ☐ Occasionally ☐ Daily Does someone help your child floss? ☐ YES ☐ NO

What type of toothbrush does your child use? ☐ Hard ☐ Medium ☐ Soft ☐ Unsure

What toothpaste does your child use? ____

What is the source of your drinking water at home? ☐ City/community supply ☐ Private well ☐ Bottled Water

Do you use a water filter at home? ☐ YES ☐ NO If YES, type of filtering system: ________________________

Please check all sources of fluoride your child recieves:

☐ Drinking water ☐ Toothpaste ☐ Over-the-counter rinse ☐ Prescription rinse/gel ☐ Prescription drops/tablets/vitamins

☐ Fluoride treatement in the dental office ☐ Fluoride varnish by pediatrician/other practitioner ☐ Other: _______________________

How frequently does your child have the following?

Snacks between meals	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Product _________________________
Candy or other sweets	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Type ____________________________
Chewing gum	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Usual Snack______________________
Soft Drinks*	☐ Rarely	☐ 1-2 times/day	☐ 3 or more times/day	Product _________________________

*(*such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)*

Please note other significant dietary habits: ____

Does your child participate in any sports or similar activities? ☐ YES ☐ NO If YES, list: ____

Does your child wear a mouthguard during these activities? ☐ YES ☐ NO If YES, type: ____

Has your child been examined or treated by another dentist? ☐ YES ☐ NO

If YES: Date of first visit: _____________________ Date of last visit: ________________ Reason for last visit: ___________________________

Were x-rays taken of the teeth or jaws? ☐ YES ☐ NO Date of most recent dental X-rays: ______________________________

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ☐ YES ☐ NO If YES, when? ___________________

Has your child ever had a difficult dental apointment? ☐ YES ☐ NO If YES, describe: ____

How do you expect your child will respond to dental treatment? ☐ Very Well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly

Is there anything else we should know before treating your child? ☐ YES ☐ NO

If yes, describe: ____

____

____________________________	__________________________	______________________	_________________________________
Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history

Treatment and Financial Consent

Every effort is being made to keep down the cost of dental care. You can help by making your payment at the time of your visit. You will be given an estimate of the approximate total fee at the beginning of any necessary treatment and definite financial arrangements will be made with you at that time.

We request that services rendered on your child's FIRST visit be paid on the day of the visit. Several methods of payment are available after that visit which we will be happy to discuss with you. They are as follows:

1. Payment at time of visit is the customary method.
2. Mastercard, Visa, or Discover
3. Insurance – We will file insurance claims as a courtesy to you at no charge. You must provide us with a current insurance card that shows mailing address and telephone number for benefit determination.
4. CareCredit - CareCredit is a flexible patient payment program, specifically designed for healthcare expenses, that makes it easier for you to get the treatment or procedures you want and need. CareCredit lets you begin your treatment or procedure immediately—then pay for it over time with low monthly payments that are easy to fit into your monthly budget.

We file dental claims electronically within 24 hours of service. If your insurance company will not accept e-claims, we will file the claim on a standard insurance claim form. It is your responsibility to provide the office with the correct insurance information.

If benefits are to be assigned to our office, we must have a Dental Insurance Authorization & Release of Information form (see below) on file that is signed by the insured or responsible party. The office policy regarding payments from your insurance company is that we will file claims only twice for a specific claim with a grace period of 30 days. If payment is not received within 30 days, a statement will be sent to you requesting payment in full and suggesting you contact your insurance company.

DENTAL INSURANCE AUTHORIZATION & RELEASE OF INFORMATION

I Hereby authorize payment of the group insurance benefits directly to the Dental Office of Pediatric Dentistry of Noblesville otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

I understand that it is my responsibility to provide the Dental Office with my current insurance information to properly file claims.

If my insurance company has not made payment to the Dental Office within 30 days of the treatment date, I agree to pay the balance due in full at that time. I understand that interest will be charged on any unpaid amounts more than 60 days past due at an annual percentage rate of 18%.

X____
Insured or Responsible Party

____
Date

Please remember that you are responsible for payment of all fees to this office. Your dental insurance plan is designed to share in the cost of your dental treatment. It may not cover the total cost of your treatment. Your insurance policy is a contract between you and your insurance company. The insurance company has no obligation to our office.

We are happy to cooperate with you and the insurance company in order to help you receive the maximum benefits available under your policy.

METHOD OF PAYMENT (please check)

CASH______CREDIT CARD_______INSURANCE______MEDICAID______CARE CREDIT______OTHER______

CONSENT

YOUR CHILD IS A MINOR, THEREFORE IT IS NECESSARY THAT A SIGNED PERMISSION BE OBTAINED FROM A PARENT OR LEGAL GUARDIAN BEFORE ANY NECESSARY DENTAL SERVICE CAN BE PERFORMED **I GIVE ELIZABETH A. TRILLET, D.M.D., AND CHAD O. HAZELRIGG, D.D.S. AND CHARLES T. FUHRER III, D.D.S.** PERMISSION TO PROVIDE MY CHILD'S DENTAL EXAM AND TREATMENT AND I WILL BE RESPONSIBLE FOR THE COST OF THE DENTAL CARE. I UNDERSTAND THAT I AM COMPLETELY FINANCIALLY RESPONSIBLE FOR ALL TREATMENT INCURRED BY THE ABOVE NAMED PATIENT IN THIS OFFICE, INCLUDING ANY AMOUNTS NOT PAID BY MY INSURANCE COMPANY (IF ANY) WITHIN 30 DAYS OF TREATMENT. I UNDERSTAND INTEREST WILL BE CHARGED ON ANY UNPAID AMOUNTS MORE THAN 60 DAYS PAST DUE AT AN ANNUAL PERCENTAGE RATE OF 18%. I PROMISE TO PAY ANY LEGAL INTEREST ON THE BALANCE DUE, TOGETHER WITH ANY COLLECTION COSTS OR ATTORNEY FEES INCURRED TO AFFECT COLLECTION OF THIS ACCOUNT SHOULD MY ACCOUNT BE TURNED OVER TO A THIRD PARTY.

SIGNED____
Parent or Guardian Date